North West London
Acute Provider Collaborative

NWL APC BOARD IN COMMON - PUBLIC MEETING - READING ROOM

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21 January 2025

13:00 GMT Europe/London

The Oak Suite, W12 Conference Centre, Hammersmith Hospital

AGENDA

- 5.3 Learning from deaths quarter 2 report - individual Trust reports 1
    - 5.3 CWFT Learning from deaths Q2 2024_25 (1).pdf 2
    - 5.3 ICHT Learning from deaths Q2 2024-25.pdf 19
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5.3 LEARNING FROM DEATHS QUARTER 2 REPORT - INDIVIDUAL TRUST REPORTS

REFERENCES

Only PDFs are attached

- 5.3 CWFT Learning from deaths Q2 2024_25 (1).pdf
- 5.3 ICHT Learning from deaths Q2 2024-25.pdf
- 5.3 LNWH Learning from deaths Q2 2024-25.pdf
- 5.3 THH APCQC LfD Report Q2 2024-25.pdf

NWL Acute Provider Collaborative Board in Common (Public)
21/01/2025
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Chelsea and Westminster Hospital NHS Foundation Trust Learning from Deaths report Quarter 2 2024/25

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Purpose of report

Purpose: Assurance

Report history

Mortality Surveillance Group, 8 November 2024	Executive Management Board, 20 November 2024	Trust Quality Committee, 26 November 2024

Executive summary and key messages

1.1. The Trust is the best performing acute (non-specialist) provider in England in terms of relative risk of mortality with a Trust wide SHMI of 0.66 (where a number below 1 is better than expected mortality) for period May 2023 and April 2024 (Source HES). This positive assurance is reflected across the Trust as both sites continue to operate significantly below the expected relative risk of mortality.

1.2. During the 12-month period to the end of September 2024; 1340 in-hospital adult or child deaths were recorded on the Trust mortality review system (Datix), of these 90% were screened and 41% had a full mortality case review closed following speciality discussion.

1.3. During Q2 24/25; There were no cases of sub-optimal care that might have or would reasonably be expected to have made a difference to the patient's outcome. For the 12 month period ending September 2024, 5 cases of sub-optimal care were identified in total and escalated for a decision on appropriate learning response.

1.4. Where the potential for improvement is identified learning is shared at Divisional review groups and presented to the Trust-wide Mortality Surveillance Group; this ensures outcomes are shared and learning is cascaded.

Strategic priorities

Tick all that apply

☐ Achieve recovery of our elective care, emergency care, and diagnostic capacity
☐ Support the ICS's mission to address health inequalities
☐ Attract, retain, develop the best staff in the NHS
☒ Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation
☐ Achieve a more rapid spread of innovation, research, and transformation

Improving how we learn from deaths which occur in our care will support identification of improvements to quality and patient outcomes.

Impact assessment

Tick all that apply

☐ Equity
☒ Quality
☐ People (workforce, patients, families or careers)
☐ Operational performance
☐ Finance
☐ Communications and engagement
☐ Council of governors

Mortality case review following in-hospital death provides clinical teams with the opportunity to review expectations, outcomes and learning in an open manner. Effective use of mortality learning from internal and external sources provides enhanced opportunities to reduce in-hospital mortality and improve clinical outcomes and experience for patients and their families.

Main report

1. Learning and Improvements

The Trust's Mortality Surveillance programme offers assurance to our patients, stakeholders, and the Board that high standards of care are being provided and that any gaps in service delivery are being effectively identified, escalated, and addressed. This report provides a Trust-level quarterly review of mortality learning for Q2 2024/25 with performance scorecard (see Appendix 1 and 2) reflecting all quarters of the financial year.

1.1. Relative Risk of mortality

The Trust uses the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) to monitor the relative risk of mortality. Both tools are used to determine the relative risk of mortality for each patient and then compare the number of observed deaths to the number of expected deaths; this provides a relative risk of mortality ratio (where a number below 100 represents a lower than expected risk of mortality).

Population demographics, hospital service provision, intermediate / community service provision has a significant effect on the numbers of deaths that individual hospital sites should expect; the SHMI and HSMR are designed to reduce this impact and enable a comparison of mortality risk across the acute hospital sector. By monitoring relative risk of mortality the Trust is able to make comparisons between peer organisations and seek to identify improvement areas where there is variance.

1.2. Summary Hospital-level Mortality (SHMI) Indicator: Trust wide

The SHMI is an NHS generated mortality risk metric; it covers 100% of patients admitted to non-specialist acute Trusts in England who died either while in hospital or within 30 days of discharge (excluding stillbirths).

Figure 1: Funnel Plot (Rebasing period up to March 2024). SHMI comparison of England acute hospital sites based on outcomes between May 2023 and April 2024 - Updated 02/10/2024.

Using the SHMI dataset, within the period between May 2023 and April 2024, there have been 93371 discharges, of which 1652 patients died either in hospital or within 30 days of discharge. The number of expected deaths was 2340.

The 'in hospital' and 'out of hospital' SHMI values are also below the expected range. Overall 75% of patients died in hospital (n=1239). Table 1 below shows that both Trust sites have similar SHMI outcomes.

Site	SHMI	LCL 95%CI	UCL 95%CI	Expected number of deaths	Observed number of deaths	Total discharges	% adms. with palliative care coding	Mean comorbidity score per spell
CWH	65.89	60.89	71.2	972	641	44139	1.45%	3.08
WMUH	73.9	69.42	78.6	1367	1011	49232	1.44%	4.15
CWHFT	70.57	67.21	74.06	2340	1652	93371	1.44%	3.64

Table 1. SHMI breakdown by site – Updated 02/10/2024

The positive assurance provided by the SHMI is reflected across the Trust as both sites continue to operate significantly below the expected relative risk of mortality:

- West Middlesex University Hospital:
  SHMI value 0.74 (1011 observed deaths, 1367 expected deaths)
- Chelsea and Westminster Hospital:
  SHMI value 0.66 (641 observed deaths, 972 expected deaths)

Diagnostic Groups: The SHMI is made up of 142 different diagnostic groups which are then aggregated to calculate the Trust's overall relative risk of mortality. The Mortality Surveillance Group monitors expected and observed deaths across diagnostic groups; where statistically significant variation is identified the group undertakes coding and care review to identify any themes or potential improvement areas.

Data Quality: The Trust identified an issue with its HES submissions where some spells were appearing incomplete and as a result were moved by NHS Digital into the diagnostic group 'residual codes unclassified'. The problem has been fixed and since May 23, the number of records appearing in this group have subsequently been reduced.

1.3. Hospital Standardised Mortality Ratio (HSMR)

The HSMR is an alternative mortality risk metric; it covers 56 diagnosis groups that account for approximately 80% of patients admitted to non-specialist acute Trusts in England who died while in hospital (including stillbirths), this metric does not include those deaths that occur shortly after discharge. The Trust's HSMR in the 12 months ending March 2024 is 79.49, lower than expected.

Trust	HSMR	Superspells	Ranking
CWH	79.49	135910	Lower than expected
ICH	71.61	198533	Lower than expected
LNWUH	96.04	160775	Lower than expected
HH	93.84	67867	Lower than expected

Table 2 – HSMR outcomes over period April 2023 to March 2024 – updated 02/10/2024

1.4. Crude mortality

Emergency spells (activity) and the deaths associated with those spells (crude number) can be used to calculate the rate of in-hospital deaths per 1000 patient spells (this calculation excludes elective and obstetric activity).

Crude mortality rates must not be used to make comparisons between sites due to the effect that population demographics, services offered by different hospitals, and services offered by intermediate / community care has on health outcomes (e.g. crude mortality does not take into account the external factors that significantly influence the relative risk of mortality at each site). Crude mortality is useful to inform resource allocation and strategic planning.

The following crude rates only include adult emergency admitted spells by age band. This approach is used as it reduces some of the variation when comparing the two sites and support understanding and trend recognition undertaken by the Mortality Surveillance Group.

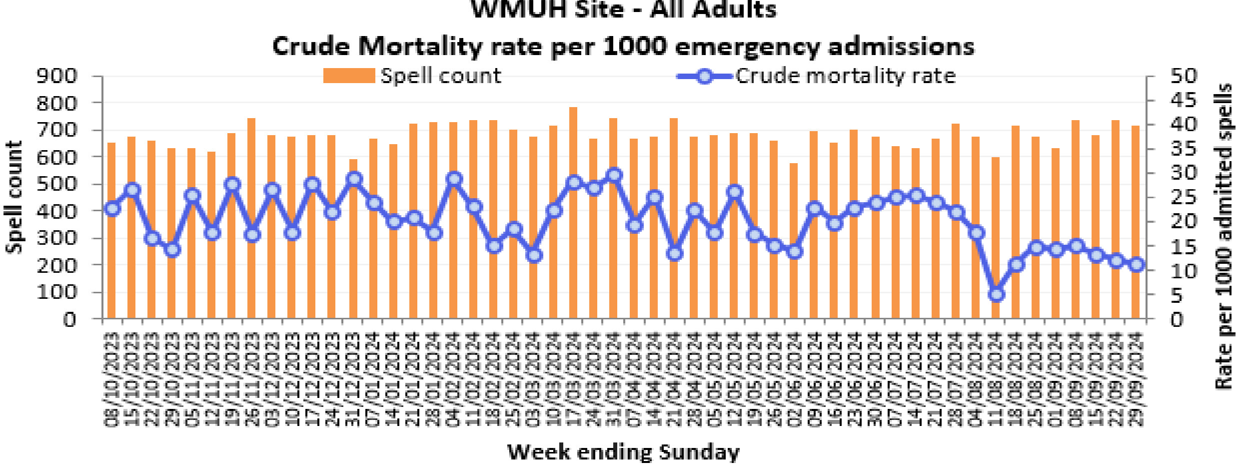


Figure 2 – Crude mortality rate per 1000 emergency admissions, West Middlesex University Hospital

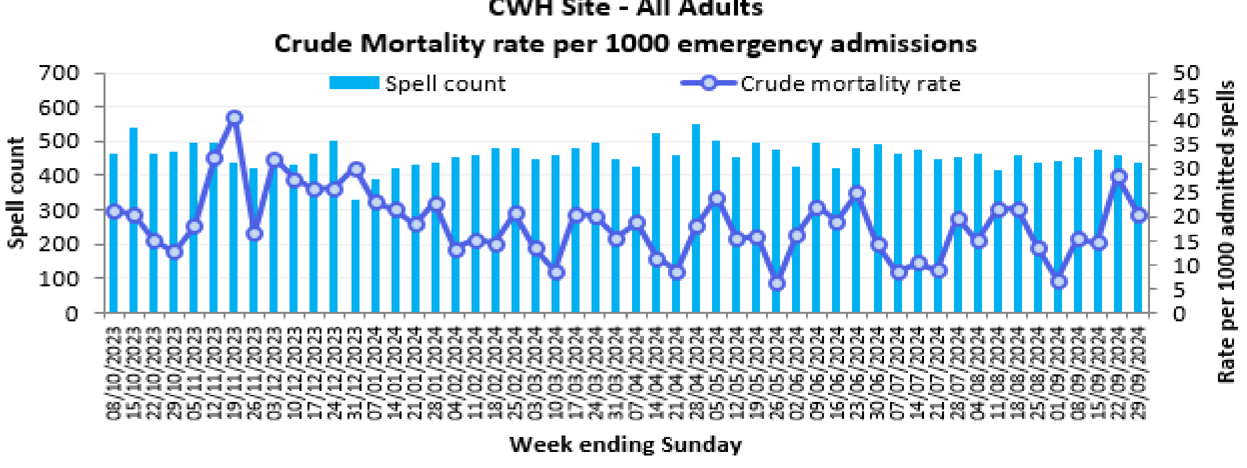


Figure 3 – Crude mortality rate per 1000 emergency admissions, Chelsea and Westminster Hospital

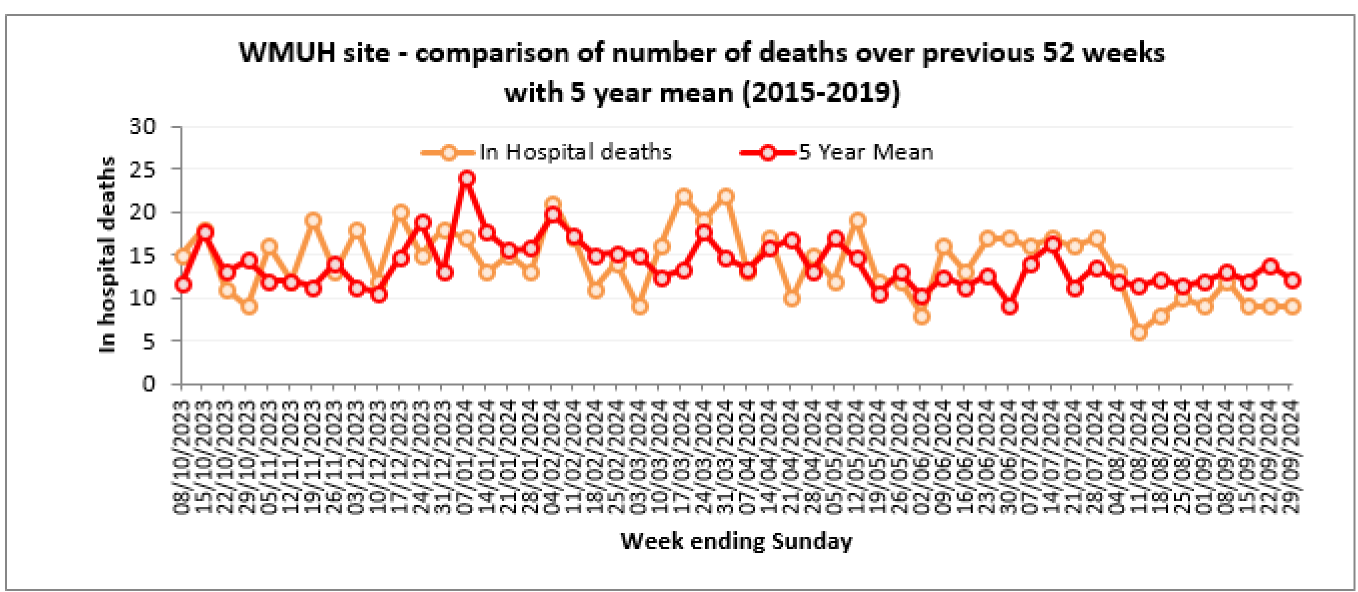


Figure 4 – Crude mortality in last 52 weeks compared with 5 year mean, West Middlesex University Hospital

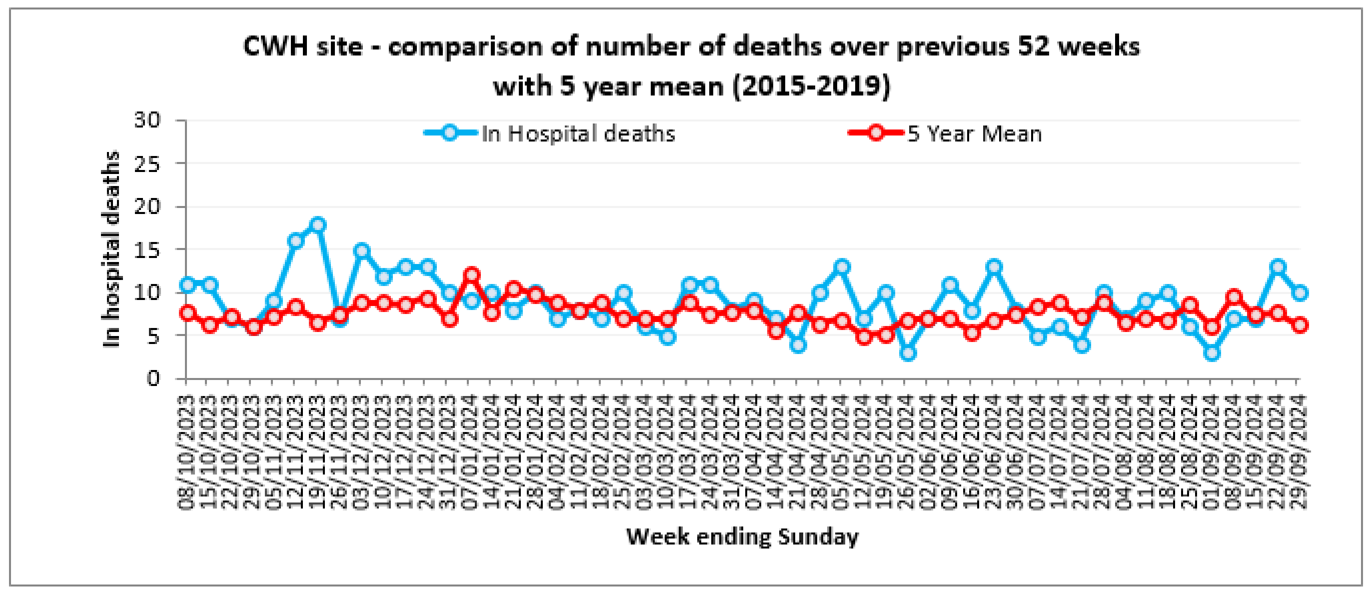
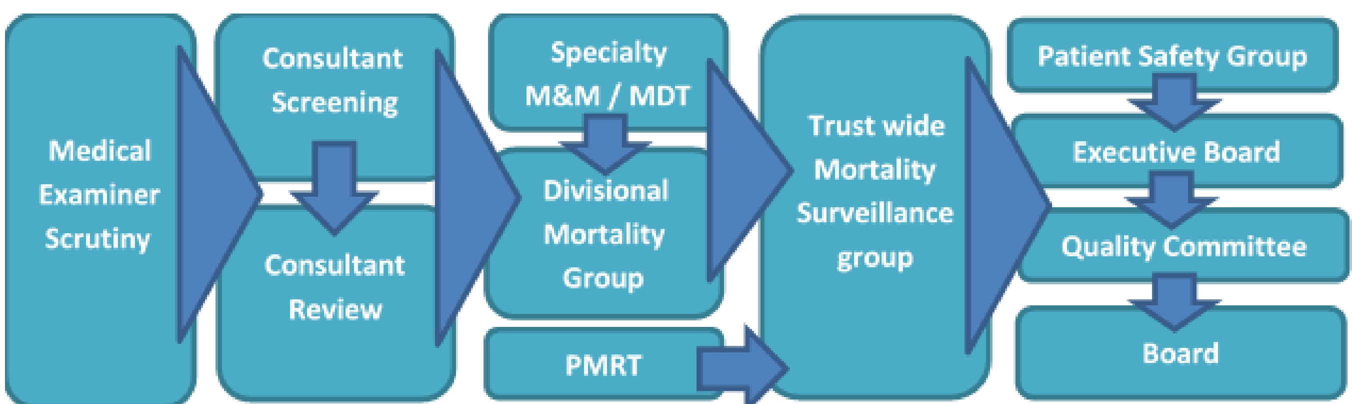


Figure 5 – Crude mortality in last 52 weeks compared with 5 year mean, Chelsea and Westminster Hospital

Crude mortality is monitored by the Mortality Surveillance Group on a monthly basis; no further review has been triggered as a result of this monitoring during this reporting period.

2. Thematic Review

The Mortality Surveillance Group (MSG) challenges assurance regarding the opportunity and outcomes from the Trust's learning from deaths approach.



MSG provides leadership to this programme of work; it is supported by monthly updates on relative risk of mortality, potential learning from medical examiners, learning from inquests, and divisional learning from mortality screening / review. MSG is a sub-group of the Patient Safety Group and is aligned to the remit of the Quality Committee.

2.1. Medical Examiner's office

An independent Medical Examiner's service was introduced to the Trust in April 2020 to provide enhanced scrutiny to deaths and to offer a point of contact for bereaved families wishing to raise concerns.

The purpose of this service is to:

- Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- Ensure the appropriate direction of deaths to the coroner
- Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- Improve the quality of death certification
- Improve the quality of mortality data

During Q2 2024/25 the medical examiners service scrutinised 100% of in-hospital adult and child deaths and identified 62 cases of potential learning for the Trust and 13 cases of potential learning for other organisations. Potential learning identified during medical examiner scrutiny is shared with the patient's named consultant, divisional mortality review group and the Trust-wide Mortality Surveillance Group. Full consultant led mortality review is required whenever the MEs identify the potential for learning.

Thematic learning from medical examiner scrutiny is reported to the Mortality Surveillance Group, Executive Management Board, and Quality Committee (via annual ME report).

2.2. Adult and child mortality review

Mortality case review provides clinical teams with the opportunity to review expectations, outcomes and potential improvements with the aim of:

- Identifying sub-optimal or excellent care
- Identifying service delivery problems
- Developing approaches to improve safety and quality
- Sharing concerns and learning with colleagues

In-hospital adult and child deaths are screened by consultant teams using the screening tool within Datix, this supports the identification of cases that would benefit from full mortality review.

Learning from review is shared at specialty mortality review groups (M&Ms / MDTs); where issues in care, trends or notable learning is identified action is steered through Divisional Mortality Review Groups and the trust-wide Mortality Surveillance Group (MSG).

Trust mortality review targets:

- 100% of in-hospital adult and child deaths to be screened
- At least 30% of all adult and child death aligned to the Emergency and Integrated Care (EIC) Division to undergo full mortality review
- At least 80% of all adult and child deaths aligned to Planned Care Division (PCD), Women's Neonates, HIV/GUM, Dermatology (WCHGD), and West London Children's Health (WLCH) to undergo mortality review
- 100% of cases aligned to a Coroner inquest to undergo full mortality review
- 100% of cases where potential learning identified by Medical Examiner to undergo full mortality review

During October 2023 to September 2024; 1340 in-hospital adult or child deaths were recorded within the Trust's mortality review system (Datix), of these 90% have been screened and 41% have had full mortality case review.

	No. of deaths	No. of cases screened only and closed	No. of cases with full mortality review	No. of cases pending screening	% Screened	% with Full Review	% Pending
Q3 23/24	388	197	191	0	100.0%	49.2%	0.0%
Q4 23/24	363	201	145	17	95.3%	39.9%	4.7%
Q1 24/25	317	146	137	34	89.3%	43.2%	10.7%
Q2 24/25	272	114	82	76	72.1%	30.1%	27.9%
Totals	1340	658	555	127	90.5%	41.4%	9.5%

Table 3: Adult and child mortality review status by financial quarter, Oct 23 – Sep 2024

Process compliance is monitored by the Divisional Mortality Review Groups, Mortality Surveillance Group, and overseen by the Patient Safety Group, Executive Management Board, and Quality Committee.

	No. of deaths	No. of cases screened and closed	No. of cases with full mortality review	No. of cases pending screening	% Screened	% with Full Review	% Pending
EIC	1088	640	351	97	**91.1%**	**32.3%**	**8.9%**
PCD	239	13	197	29	**87.9%**	**82.4%**	**12.1%**
SCD	7	5	1	1	**85.7%**	**14.3%**	**14.3%**
WLCH	6	0	6	0	**100.0%**	**100.0%**	**0.0%**
Totals	**1340**	**658**	**555**	**127**	**90.5%**	**41.4%**	**9.5%**

Table 4: Adult and child mortality review status by Division, Oct 23 – Sep 2024

Gaps in process compliance at Specialty and Divisional level are monitored by the Mortality Surveillance Group. Divisional plans to achieve the required compliance are reported to the Mortality Surveillance Group and Executive Management Board.

	No. of deaths	No. of cases screened and closed	No. of cases with full mortality review	No. of cases pending screening	% Screened	% with full review	% Pending
Acute Medicine	383	275	101	7	**98.2%**	**26.4%**	**1.8%**
Burns	4		4		**100.0%**	**100.0%**	**0.0%**
Cardiology	49	21	28		**100.0%**	**57.1%**	**0.0%**
Care Of Elderly	276	176	76	24	**91.3%**	**27.5%**	**8.7%**
Colorectal	10	2	6	2	**80.0%**	**60.0%**	**20.0%**
Diabetes/Endocrine	77	63	10	4	**94.8%**	**13.0%**	**5.2%**
Emergency Department	94		84	10	**89.4%**	**89.4%**	**10.6%**
Gastroenterology	52	24	24	4	**92.3%**	**46.2%**	**7.7%**
General Surgery	30	6	15	9	**70.0%**	**50.0%**	**30.0%**
Gynaecology	1			1	**0.0%**	**0.0%**	**100.0%**
Haematology	8	3	1	4	**50.0%**	**12.5%**	**50.0%**
HDU	1		1		**100.0%**	**100.0%**	**0.0%**
Hepatology	6	1		5	**16.7%**	**0.0%**	**83.3%**
HIV	6	5	1		**100.0%**	**16.7%**	**0.0%**
ICU	149	2	138	9	**94.0%**	**92.6%**	**6.0%**
Medical Oncology	21	11	1	9	**57.1%**	**4.8%**	**42.9%**
Paediatric Medical	6		6		**100.0%**	**100.0%**	**0.0%**
Palliative Care	4	3	1		**100.0%**	**25.0%**	**0.0%**
Respiratory	83	43	18	22	**73.5%**	**21.7%**	**26.5%**
Stroke	34	20	7	7	**79.4%**	**20.6%**	**20.6%**
Trauma / Orthopaedics	32	2	27	3	**90.6%**	**84.4%**	**9.4%**
Urology	13	1	6	6	**53.8%**	**46.2%**	**46.2%**
Rheumatology	1			1	**0.0%**	**0.0%**	**100.0%**
Total	**1340**	**658**	**555**	**127**	**90.5%**	**41.4%**	**9.5%**

Table 5: Adult and child mortality review status by Specialty, Oct 23 – Sep 2024

The Trust operates a learning from deaths process that places significant value on case discussion and learning undertaken within specialty and divisional multi-disciplinary teams. These meetings are scheduled throughout the year (monthly) and supported by a wide range of clinical staff and the clinical governance department. This approach to quality ensures learning is agreed and widely cascaded.

Process compliance metrics should be reported to the Quality Committee and Board in arrears as some cases are still progressing and should therefore not be used to draw conclusions regarding process compliance.

2.3. Perinatal mortality review

The Perinatal Mortality Review Tool (PMRT) is a national mandatory monitoring and assurance dataset developed by MBRRACE-UK. It is used to collect very detailed information about the care mothers and babies have received throughout pregnancy, birth and afterwards. The purpose of the PMRT is to support hospital learn from deaths by providing a standardised and structured review process.

The PMRT is designed to support review of:

- All late fetal losses (22 weeks + 0 days to 23 weeks + 6 days);
- All antepartum and intrapartum stillbirths;
- All neonatal deaths from birth at 22 weeks + 0 days to 28 days after birth;

Learning from these cases is captured only within the PMRT and not duplicated within the Trust's mortality review system (Datix). The national target is to complete PMRT review within 6 months. The reporting time scales for PMRT do not align within the timescales of this report therefore the below data is 2 quarters behind. During the 3 month period ending March 2024; 15 perinatal deaths were reported to the MBRRACE-UK and a total of 30 cases were identified as requiring PMRT review (including post-neonatal deaths not reported via MBRRACE-UK).

	No. reported	Not supported for review	Review in progress	Review completed	Grading of care: no. with issues in care likely to have made a difference to outcome
Stillbirths and late fetal losses	21	11	1	9	**0**
Neonatal and post-natal deaths	9	2	0	7	**0**

Table 6: PMRT review status by case category, 1 January 24 – 31 March 24

Learning from PMRT review is reported to the Mortality Surveillance Group; where sub-optimal care that could have impacted outcome is identified cases are escalated as potential serious incidents. The organisation publishes a Learning from Serious Incidents report on a quarterly basis and outcomes / learning is received by the Patient Safety Group and Executive Management Board on a monthly basis.

2.4. Learning Disabilities Mortality Review (LeDeR)

The national Learning Disabilities Mortality Review (LeDeR) programme was established in May 2015 in response to the recommendations from the Confidential Inquiry into premature deaths of people with learning disabilities. From January 2022, LeDeR reports have included deaths of autistic people without a learning disability. In response to this change and following stakeholder engagement, the new name for the LeDeR programme is 'Learning from Life and Death Reviews – people with a learning disability and autistic people'.

The Trust reported 5 deaths to LeDeR in Q2.

Ref	Month of Death	Approval status	Specialty	CESDI grade
MM12943	Jul	Closed	Acute Medicine	Grade 0
MM12947	Jul	Closed	Stroke	Grade 0
MM13177	Sep	Closed	Acute Medicine	Grade 0
MM13241	Sep	Closed	Acute Medicine	Grade 0
MM13331	Sep	Awaiting Specialty Sign Off	General Surgery	Grade 0

Table 7: LeDer cases during July – Sep 2024

The LeDeR programme seeks to coordinate, collate and share information about the deaths of people with learning disabilities and autistic people so that common themes, learning points and recommendations can be identified and taken forward at both local and national levels. The Trust is committed to ensuring deaths of patients with known / pre-diagnosed learning disabilities and /or autism are reported to the LeDeR programme and reviewed accordingly.

Since July 2023 LeDeR notifications are only for those aged 18 years and over. The NWL ICB have LeDeR representatives attend Child Death Review Meetings. This ensures that the death is looked at from a health inequalities/LeDeR perspective. The Child Death Review Team monitor the themes from reviews and continue to share them with the NWL ICB LeDeR team.

3. Areas of focus

The Trust's mortality review programme provides a standardised approach to case review designed to improve understanding and learning about problems and processes in healthcare associated with mortality, and also to share best practice.

Where problems in care are identified these are graded using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categories:

- Grade 0: No suboptimal care or failings identified and the death was unavoidable
- Grade 1: A level of suboptimal care identified during hospital admission, but different care would NOT have made a difference to the outcome and the death was unavoidable
- Grade 2: Suboptimal care identified and different care MIGHT have made a difference to the outcome, i.e. the death was possibly avoidable
- Grade 3: Suboptimal care identified and different care WOULD REASONABLY BE EXPECTED to have made a difference to the outcome i.e. the death was probably avoidable

During the past 12 months, 483 full mortality reviews have been closed following discussion at specialty, divisional or Trust wide mortality review groups.

Period	CESDI 0	CESDI 1	CESDI 2	CESDI 3
Q3 23/24	152	35	2	0
Q4 23/24	116	17	2	0
Q1 24/25	108	8	1	0
Q2 24/25	42	0	0	0
Total	**418**	**60**	**5**	0

Table 8: Closed mortality cases by CESDI grade Oct 23 – Sep 2024

Five cases were identified via the mortality review process as a CESDI 2 (different care MIGHT have made a difference to the outcome, i.e. the death was possibly avoidable). Each of these cases were escalated to the executive for a decision on appropriate learning response.

All cases of suboptimal care are presented to the Mortality Surveillance Group to ensure shared learning across the Trust. There were four cases identified at West Middlesex hospital and one case identified at Chelsea and Westminster hospital. This is within expectations in a patient cohort with increased frailty and comorbidities.

Mortality Ref	CESDI grade	Incident Ref	Site	Area	Category	Incident investigation status
MM11675	CESDI 2	INC124217	WMH	Care Of Elderly	Imaging/Radiation	Finally approved
MM11408	CESDI 2	INC122160	WMH	Paediatric Accident and Emergency	Death: Unexpected / unexplained	Finally approved
MM12159	CESDI 2	INC128857	CWH	Acute Medicine	Patient falls	Finally approved
MM12031	CESDI 2	INC129576	WMH	Gastroenterology	Provision of care / treatment	Finally approved
MM12743	CESDI 2	INC141129	WMH	Acute Medicine	Transfusion, Blood/Blood Products	Pending sign off

Table 9: CESDI grade 2 cases linked to incident investigations, Oct 23 – Sep 2024

Population demographics, hospital service provision, intermediate/community service provision all have an effect on the numbers of incidents occurring on each site. Mortality reviews graded CESDI 2 and 3 will have an associated patient safety incident reported.

The Trust is committed to delivering a just, open and transparent approach to investigations that reduces the risk and consequence of recurrence. Key themes from incident investigations linked to mortality review are submitted to the Patient Safety Group and the Executive Management Group for shared learning and consideration of whether further Quality Improvement Projects, deep-dives, or targeted action is required.

The organisation publishes a learning from Safety learning responses on a monthly basis and outcomes/learning is received by the Patient Safety Group, local Quality Committee and Executive Management Board on a monthly basis (with case outlines and associated actions).

There were 60 cases graded as a CESDI 1 (e.g. level of suboptimal care identified during hospital admission, but different care or management would NOT have made a difference to the outcome and the death was unavoidable). Learning from CESDI 1 cases provides the Trust and our teams with excellent learning from which to develop our improvement approaches.

The following specialist teams have successfully identified CESDI 1 learning opportunities from across the patient journey (not necessary occurring whilst the patient was under the care of that speciality). The identification of CESDI grade 1 cases should not be used to draw conclusions regarding quality and safety within the identifying specialty.

Specialty	CW	WM	Total
Acute Medicine	12	8	20
Care Of Elderly	5	5	10
Cardiology		8	8
ICU	6	1	7
Gastroenterology		5	5
Trauma / Orthopaedics	2	3	5
Respiratory	2		2
Colorectal		1	1
Medical Oncology	1		1
Diabetes/Endocrine	1		1
Total	**29**	**31**	**60**

Table 10: CESDI grade 1 cases by Specialty, Oct 23 – Sep 2024

The Divisional Mortality Review Groups provide scrutiny to mortality cases so as to identify themes and escalate any issues of concerns.

Following discussion of cases graded CESDI 1-2, the key themes / issues identified via mortality review and flagged via the Mortality Surveillance Group between Oct 2023 and September 2024 include:

- Timely and accurate completion of Treatment Escalation Plans (TEP) and DNAR discussions. Consultant level discussions, with clear documentation translated into the form on Cerner.
    - Failure to complete a DNAR form has resulted in some patients being resuscitated despite it being documented in the notes they are not for CPR. It is was also highlighted that CPR must be initiated until it is confirmed the patient is DNAR.
- Unnecessary invasive monitoring and/or procedures at end of life
- Communication with family to ensure their understanding of care plan and to manage family expectations.
- Gaps in end of life care:
    - Recognition and escalation of the actively dying patient, with early involvement of palliative care;
    - The importance of good communication with families of palliative patients, ensuring risks and benefits of an approach are clearly explained;

- Appropriateness of ordering diagnostics on an actively dying patient when a clinical assessment may be more fitting - this should be discussed with the MDT and a specialist consultant e.g. stroke

4. Conclusion

The outcome of the Trust's mortality surveillance programme continues to provide a rich source of learning that is supporting the organisation's safety improvement objectives.

The Trust continues to be recognised as having one of the lowest relative risk of mortality (SHMI) across the NHS in England. The Trust is committed to better understanding the distribution of mortality according to the breakdown of our patient demographics (Appendix 2) and ensure we tackle any health inequalities that we identify in doing so.

As part of the rollout of the Patient Safety Incident Response Framework (PSIRF) the mortality review template is being used as a learning response tool and the follow-up of safety action plans will be done via the Divisional Mortality Review Groups as well as the Mortality Surveillance Group going forward. Any cases that are escalated as CESDI 2 and 3 are also brought to the weekly Initial Incident Review Group for a proportionate decision on learning response and approval by the executive team.

5. Glossary

5.1. **Medical Examiners** are responsible for reviewing every inpatient death before the medical certificate cause of death (MCCD) is issued, or before referral to the coroner in the event that the cause of death is not known or the criteria for referral has been met.. The ME will also discuss the proposed cause of death including any concerns about the care delivered with bereaved relatives.

5.2. **Specialty M&M** reviews are objective and multidisciplinary reviews conducted by specialties for cases where there is an opportunity for reflection and learning. All cases where ME review has identified issues of concern must be reviewed at specialty based multi-disciplinary Mortality & Morbidity (M&M) reviews.

5.3. **Child Death Overview Panel (CDOP)** is an independent review aimed at preventing further child deaths. All child deaths are reported to and reviewed through Child Death Overview Panel (CDOP) process.

5.4. **Perinatal Mortality Review Tool (PMRT)** is a review of all stillbirths and neonatal deaths. Neonatal deaths are also reviewed through the Child Death Overview Panel (CDOP) process. Maternal deaths (during pregnancy and up to 12 month post-delivery unless suicide) are reviewed by Healthcare Safety Investigation Branch and action plans to address issues identified are developed and implemented through the maternity governance processes.

5.5. **Learning Disabilities Mortality Review (LeDeR)** is a review of all deaths of patients with a learning disability. The Trust reports these deaths to the Local integrated care boards (ICBs) who are responsible for carrying out LeDeR reviews. SJRs for patients with learning disabilities are undertaken within the Trust and will be reported through the Trust governance processes.

Appendix 1 - Performance Scorecard

	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Comments	National LfD min. requirement?
Summary data						
Total no. deaths (adult and children)	388	363	317	272	Inpatients deaths only	
Total no. adult deaths	387	359	316	272	Inpatients over 18 years age	Y
Total no. child deaths	1	4	1	6	Inpatients over 28 days and less than 18 year only	
Total no. neonatal deaths	13	11	7	10	Inpatients livebirths under 28 days of age	
Total no. stillbirths	8	13	7	10	Inpatient not live births	
Deaths reviewed by Medical Examiner	100%	100%	99.7%	100%	% of total deaths (row 3)	
Deaths referred for Level 2 review	53%	43%	50%	43%	% of total deaths (row 3)	
Level 2 reviews completed	93%	87%	75%	36%	% of total referrals this quarter	Y
Requests made by a Medical Examiner (Potential learning identified)	51%	43%	53%	53%	% of total referrals	
Potential learning identified (Screening)	35%	33%	35%	43%	% of total referrals	
Concerns raised by family / carers (Screening)	9%	8%	11%	10%	% of total referrals	
Patients with learning disabilities (Screening)	1%	3%	1%	3%	% of total referrals	
Patients with severe mental health issues (Screening)	0%	1%	0%	0%	% of total referrals	
Unexpected deaths (Screening)	9%	10%	11%	9%	% of total referrals	
Requests made by speciality mortality leads through local Mortality and Morbidity review processes	36%	35%	27%	16%	% of total referrals	
Other reason (Linked SI, Inquest, Nosocomial Covid, DMRG request)	25%	11%	8%	1%	% of total referrals	
CESDI 0 - No suboptimal care	79%	81%	90%	100%	% of cases reviewed (&closed)	
CESDI 1 - Some sub optimal care which did not affect the outcome	18%	12%	7%	0%	% of cases reviewed (&closed)	
CESDI 2 - Suboptimal care – different care might have made a difference to outcome (possible avoidable death)	1%	1%	1%	0%	% of cases reviewed (&closed)	
CESDI 3 - Suboptimal care - would reasonably be expected to have made a difference to the outcome (probably avoidable death)	0%	0%	0%	0%	% of cases reviewed (&closed)	Y

Table 11. Trust mortality review data as at 02/10/2024

Appendix 2 – Ethnicity breakdown (for Total no. deaths adult and children)

During Q2 24/25, the recording of the patients ethnicity within the Datix mortality module was changed. The system was reconfigured to capture the patient's ethnicity from the patients contact record instead from a singular question within the mortality module. This enable triangulation of ethnicity data across all our Datix modules including incidents, complaints and claims. Work is ongoing to import ethnicity data from other data sources into Datix for cases reported prior to 1st April 2024.

	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Total
Data import pending	362	353			715
White - British	11	6	141	131	289
Other - Not Stated	4		51	48	103
White - Any Other White Background	2		34	16	52
Asian or Asian British - Indian	3	1	25	19	48
Other - Any Other Ethnic Group	2		22	12	36
Asian - Any Other Asian Background	2	2	17	15	36
Black or Black British - Caribbean	1		5	14	20
Asian or Asian British - Pakistani			4	5	9
White - Irish		1	5	3	9
Black or Black British - African	1		6	2	9
Mixed - Any Other Mixed Background			1	3	4
Asian or Asian British - Bangladeshi			2	2	4
Other - Chinese			1	1	2
Mixed - White and Black African			2		2
Black - Any Other Black Background			1	1	2
Total	388	363	317	272	1340

NWL Acute Provider Collaborative Board in Common (Public)
21/01/2025
Item number: #
This report is: Public

Imperial College Healthcare NHS Trust Learning from Deaths report Quarter 2, 2024/25

Authors: Jack Pegg and Shona Maxwell
Job titles: General manager and Chief of staff, Office of the Medical Director

Accountable director: Julian Redhead and Raymond Anakwe
Job title: Medical directors

Purpose of report

Purpose: Information or for noting only

This report presents the data from the Learning from Deaths programme for Quarter Two (Q2) of 2024/25 for information. It is a statutory requirement for Trusts to present this information to their public boards. This will be achieved through presentation to our quality committee and standing committee, with an overarching summary paper drawing out key common themes and learning from the individual reports from the four NWL acute provider collaborative (APC) trusts presented to the Board in common, following review at the APC quality committee.

Report history

Outline committees or meetings where this item has been considered before being presented to this meeting.

Learning from death forum
08/10/2024
The group discussed and agreed the content of this report, including themes for learning and improvement.

Executive Management Board Quality Group (EMBQ) and EMB
October 2024
The committees noted the findings from our learning from deaths programme and approved the report for onward submission to Quality Committee.

Quality Committee
05/11/2024
The committee noted the report and approved it for onward submission to APCQC and BiC, where it will be available in the reading room for information.

Executive summary and key messages

1.1. Our mortality rates remain statistically significantly low when compared nationally.

1.2. All deaths in the quarter have been reviewed by the Medical Examiner, with cases where there are concerns about the quality of care referred for structured judgment review (SJR). The majority of SJRs completed identified no suboptimal care, 3 identified some sub-optimal care which might have made a difference to the patient's outcome.

1.3. This level of scrutiny is important to ensure all issues are considered and importantly that questions from the bereaved are highlighted and answered. The low number of issues found that affected the outcome is a positive reflection of the care delivered.

1.4. Completed SJRs in this quarter have identified examples of excellent team working and good communication with families. There were no new themes for improvement identified. A recurring area for improvement is around the importance of effectively responding to patient deterioration. This was found in a small number of cases (n=3) in this quarter. Improving treatment of patients with signs or deterioration remains a safety priority, learning and improvements identified through recent SJRs are informing the improvement plan.

1.5. We continue to undertake reviews where we identify rising mortality rates. Review of an increase in crude deaths in maternity in August 2024 (n=7) has been completed with no new clinical concerns identified. We are currently reviewing Hammersmith Hospital and the Cardiology service due to recent increases in HSMR, although they remain within expected range. A review of the Asthma and Acute Myocardial Infarction (AMI) diagnostic groups are also underway. All reviews will be presented to the Learning from Death forum and details included in Q3 report.

1.6. New statutory requirements relating to death certification came into effect on 9 September 2024 with no issues to escalate. This followed changes to our internal processes to make the service more effective for bereaved families and engagement with community partners to ensure we were prepared for the new ways of working required across the system.

1.7. Further work to analyse ethnicity data for deceased patients has been completed in this quarter. This includes the incorporation of demographic details from NWL Whole Systems Integrated Care (WSIC) platform that has reduced our rate of unknown ethnicity from 17% to 9% for our patients. An update on this work is provided in full in this paper.

Strategic priorities

Tick all that apply

☐ Achieve recovery of our elective care, emergency care, and diagnostic capacity

☐ Support the ICS's mission to address health inequalities

☐ Attract, retain, develop the best staff in the NHS

☒ Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation

☐ Achieve a more rapid spread of innovation, research, and transformation

Improving how we learn from deaths which occur in our care will support identification of improvements to quality and patient outcomes.

Impact assessment

☐ Equity

☒ Quality
☐ People (workforce, patients, families or careers)
☐ Operational performance
☐ Finance
☐ Communications and engagement
☐ Council of governors

Risk impact: There is an ongoing risk around delays with issuing MCCDs which impact our bereaved families. This is being mitigated through a business case to recruit additional ME time and by streamlining service processes.

Main report

2. Learning and Improvements

2.1. Learning from Deaths (LFD) is a standard monthly agenda item on all Divisional Quality and Safety meetings where developments in the LFD agenda and learning is shared which is then disseminated to all the directorates and throughout the division.

2.2. Outcome reports from all completed SJRs are shared with the relevant directorate and divisional leads so that the learning and improvements identified through these reviews can be reviewed locally and discussed at quality and safety meetings.

2.3. 29 SJRs completed in this quarter (58%) have identified cases where the patient received good or excellent care. 20 cases (40%) identified good communications with next of kin, which has been a theme across previous quarters.

2.4. 5 cases (10%) were identified as having good documentation in the Trust EPR however, 6 other cases (12%) identified an issue with documentation following the case note review.

2.5. 3 cases (7%) showed issues around the importance of effectively responding to patient deterioration. This is a recurring area for improvement identified through SJRs. Improving treatment of patients with signs of deterioration remains a safety priority.

2.6. The 3 SJR cases where it was identified that there was some sub-optimal care that might have made a difference to the patient outcome all occurred within intensive care although there are no common themes from the reviews.

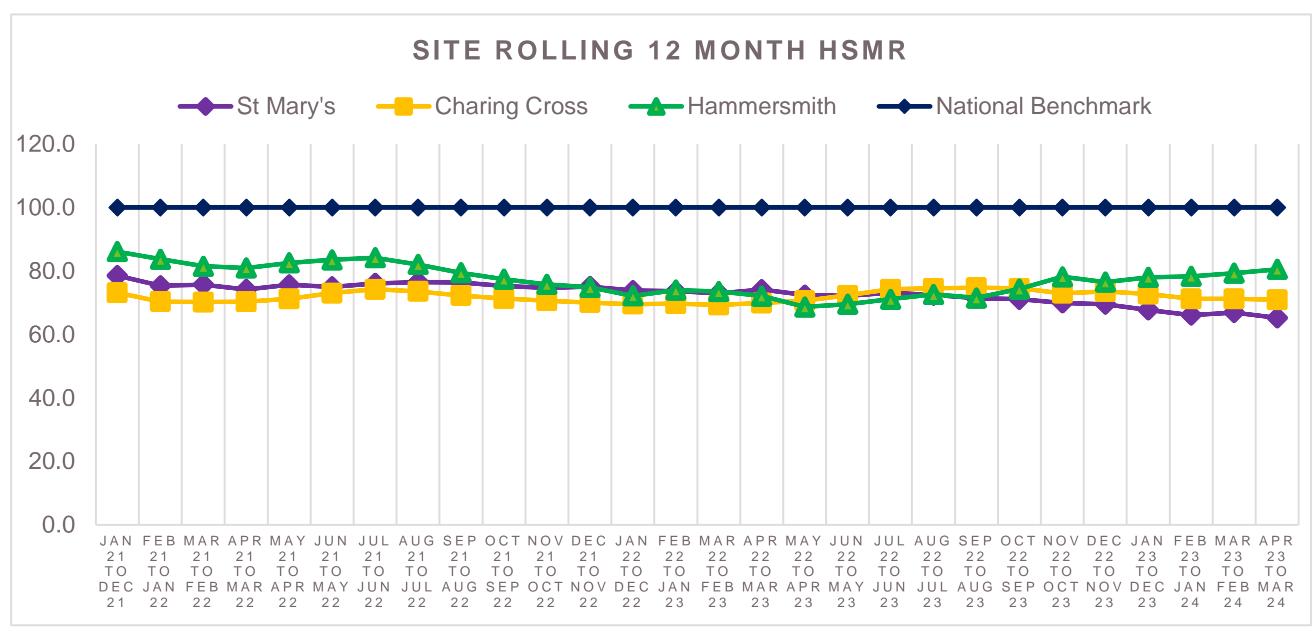
3. Key themes

3.1. Mortality rates

3.1.1. Our mortality rates remain statistically significantly low. Our rolling 12-month HSMR has increased slightly to 73.7 (compared to 71.2 in the previous quarterly report) and is 3rd lowest when compared nationally, compared to 6th lowest in the previous quarterly report. Our SHMI has decreased slightly and remains the second lowest at 73.66.

3.1.2. The graph below shows rolling 12-month HSMR scores for the 3 sites over a 3-year period to December 2023. HSMR for Charing Cross and St Mary's are consistently low, with Hammersmith varying more but always within or below expected range, and never over 100.

3.1.3. The graph demonstrates a period of recent increase at Hammersmith. This will be linked to the rising HSMR in Cardiology and recent alerts for the acute myocardial infarction diagnostic group due to the services operating on that site. This is being reviewed by the Hospital Medical Director for Hammersmith Hospital. Findings will be included in Q3 report.



3.2. **Diagnostic group reviews**

3.2.1. Reviews into the AMI and Asthma diagnostic groups have begun following alerts in September 2024. A review of non-AMI deaths in Cardiology has also begun following an increase in HSMR score above the national benchmark of 100 in August 2024, although this score is still within the expected range. These reviews will be completed in Q3 and included in the next Learning from Deaths report.

3.2.2. No new diagnostic group reviews have been completed in this quarter.

3.2.3. An increase in crude mortality rate for Maternity and Cardiology directorates was identified for the month of August 2024. Maternity had 7 deaths in the month, all of which were reviewed and no new clinical concerns identified. All deaths will go through the PMRT process with any cases where issues in care reviewed at the Death Review Panel.

3.2.4. The deaths within Cardiology (n=17) are still under review by the service; updates will be included in the Q3 report.

3.3. **Medical Examiner reviews**

3.3.1. The Medical Examiner (ME) service continues to provide independent scrutiny of 100% of inpatient deaths. The service made 107 referrals to the Coroner in this quarter, which is a decrease from 131 cases in previous quarter. The Coroner has informed us that 31 of these cases will be taken forward to an inquest.

3.3.2. The most common reason for referral to the Coroner in previous quarters is when violence, trauma or injury are involved because of the major trauma centre at St Mary's. However, the most common reason for a referral in this quarter has been when a medical procedure or treatment had been involved in the death (34%). A number of these cases include patients who had a procedure or treatment in another hospital before transferring to ICHT. These cases are all reviewed to decide if incidents have occurred that require further investigation, there is nothing to escalate but this is under constant monitoring.

3.3.3. The ME service and legal services teams continue to meet weekly to share information about new inquests ahead of Coroner notification to ensure reviews and file preparation can take place at an earlier stage.

3.3.4. All non-coronial deaths within London boroughs of Hammersmith & Fulham and Westminster are now scrutinised by the Medical Examiner service following implementation of the death certification reforms on 9 September. The service scrutinised 161 non-acute deaths in this quarter, an increase on previous quarters as more primary care and independent providers came on board with the process before statutory

implementation. 53 non-acute deaths were scrutinised in the three-week period from statutory implementation to the end of quarter 2 (9 to 30 September).

3.3.5. The service has continued work to improve the timeliness of issuing MCCDs for all deaths. The service now provides 85% of urgent MCCDs within 24 hours of the death occurring and 63% of non-urgent deaths within 3 calendar days of the death occurring, both up from around 50% at the start of this quarter when improvement work began.

3.3.6. The service has embedded monthly governance processes to monitor KPIs and investigate cases that do not meet expected timeliness in order to identify potential improvements. Further work to reduce delays is already underway, including more focussed support and engagement with clinical directors and heads of specialties when their specialties do not meet expected timelines.

3.4. Structured Judgement reviews (SJR)

3.4.1. The percentage of inpatient deaths referred for a SJR in this quarter is consistent with previous quarter (13% compared to 12% in Q1).

3.4.2. The ‘unexpected death’ trigger remains the most used trigger for an SJR referral (56% of all referrals in this quarter).

3.4.3. 77% of SJRs completed for deaths occurring in this quarter (n=33) found no suboptimal care (CESDI 0) compared to 86% in Q1 and 83% in Q4. Reviews have identified evidence of excellent care in many cases.

3.4.4. A further 16% of reviews (n=7) found that some suboptimal care was identified but that this did not affect the patient outcome (CESDI 1) compared to 12% in Q1 and 9% in Q4. The patient safety team and divisional leads review all CESDI 1 cases to decide whether an incident occurred; these cases are then managed through the incident process. One case in this quarter has been confirmed as no harm and one as low harm following review.

3.4.5. 7% of reviews into deaths occurring in this quarter (n=3) found that suboptimal care may have made a difference to the patient outcome (CESDI 2) compared to 1 case in Q1. All 3 cases occurred in intensive care but we did not identify any other common themes.

3.4.6. Reviews in this quarter found no cases where it would reasonably be expected to have made a difference to the outcome (CESDI 3).

3.4.7. A directorate breakdown of SJR outcomes from this quarter is in the table below.

Directorate	CESDI 0	CESDI 1	CESDI 2	CESDI 3	Total
Acute and Specialist Medicine (CXH)	4	1	0	0	5
Acute and Specialist Medicine (SMH)	1	3	0	0	4
Cardiac	5	0	0	0	5
Clinical Haematology	1	0	0	0	1
Critical Care	15	0	3	0	18
General Surgery and Vascular	2	0	0	0	2
Renal	1	0	0	0	1
Specialist Medicine (HH)	1	0	0	0	1
Trauma	2	2	0	0	4
Urgent care and Emergency Medicine	6	1	0	0	7

3.4.8. All cases with a CESDI 2 or 3 outcome automatically trigger an immediate incident review (IIR). Once all investigations have been completed, the case is discussed at the Death Review Panel, which triangulates outcomes from all reviews and investigations and agrees outcome and learning and improvements that need to be implemented.

3.4.9. The Death Review Panel reviewed 1 case in this quarter for a neonatal death that occurred in November 2023. The panel agreed with the PMRT outcome that the care and support given to the baby and family at the Trust should be commended.

4. Other mortality review processes

4.1. PMRT

4.1.1. The maternity and neonatal services have made 10 referrals to MBRRACE in this quarter following one late miscarriage, four stillbirths and five neonatal deaths. The PMRT panel have completed immediate review of 5 of these cases, identifying care or service delivery issues in one case that has also triggered an IIR. The Death Review Panel will review this case once all investigations have completed. Dates have been set for the PMRT panel to review the remaining cases.

4.1.2. 12 PMRT panels have concluded in this quarter with four cases (25%) identifying issues with care. The Death Review Panel will discuss these cases once all investigations are complete.

4.1.3. Recent PMRTs have identified some areas for improvement including around use of formal interpretation services (and avoiding the use of family/friends for interpretation), use of low dose aspirin when risk factors are present, availability of bereavement guidance in some settings and documentation of neonatal management plans. These are known issues with improvements underway.

4.2. LeDeR

4.2.1. Four SJRs have been completed in this quarter for patients with a learning disability and all reviews found no sub-optimal care in these cases.

4.2.2. There were common themes identified from these reviews around excellent communication with families and support offered from the safeguarding team. The care provided for two patients by the intensive care team was commended in these reviews.

4.2.3. The Safeguarding team have completed LeDeR referrals for all cases that occurred.

4.3. CDOP

4.3.1. Joint West London Children's Healthcare have completed internal mortality reviews for the 6 paediatrics patients who died in this quarter with no-suboptimal care identified.

4.3.2. CDOP referrals have been made for all deaths and detailed investigations will now take place. These reviews can take several months.

4.3.3. 6 Child Death Review meetings (CDRMs) were completed in this quarter with no concerns or learning identified for the Trust. However, one case commented on the communication between all tertiary teams involved not always being available. The Trust was also commended in two cases for the care and support provided to the patient and their family.

5. Areas of focus

5.1. Ethnicity

5.1.1. Analysis conducted in quarter one of ethnicity data of patients who died in the Trust from 2017 to 2023 identified lower than expected mortality rates for all ethnic groups but that we had a slightly higher than average number of patients where ethnicity was unknown.

5.1.2. In this quarter, we have completed work to include ethnicity data from NWL Whole System Integrated Care (WSIC) platform into our data set with the aim of improving data quality and reducing unknown numbers.

5.1.3. The percentage of deaths in 2024/25 where ethnicity is unknown has reduced from 17% when only using data from Cerner to 9% for the combined data set (see appendix B).

5.1.4. There are also differences in numbers of deaths in each ethnicity, as our 'unknowns' become 'known'. The most notable differences are in the Any Other White Background (+29 deaths), Indian (+15 deaths), Pakistani (+10 deaths), and Caribbean (+16 deaths) ethnic groups. The number of patients categorised as 'Any other ethnic group' has decreased by 25 patients. In addition, for some ethnic groups with smaller populations or cohorts, the minor numerical differences result in significant percentage variations.

5.1.5. Work continues with the support of the Health Inequalities programme team to analyse this data from a population health perspective and to understand any inequalities in our

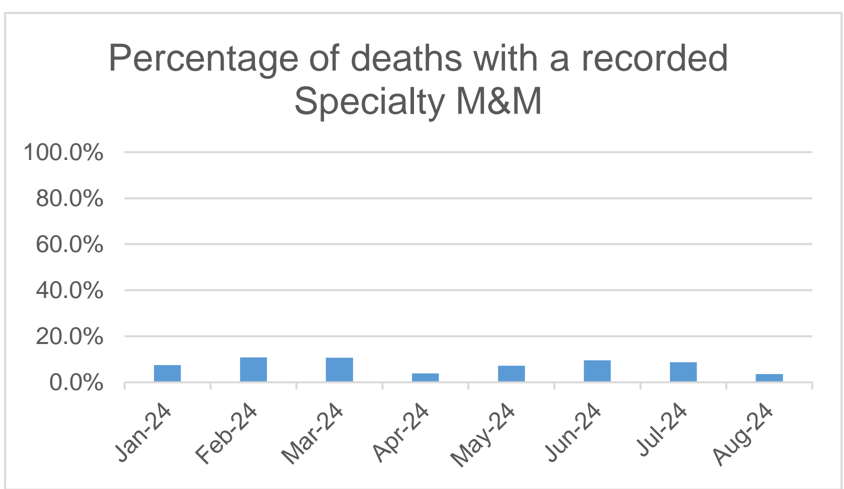
services. The next steps will be to include data relating to hospital services used by deceased patients to reveal any differences in healthcare access or use of services. We will also bring in additional demographic details, including age, gender, deprivation and primary language to expand the data set used and widen this analysis work.

5.2. **Specialty Mortality and Morbidity meetings**

5.2.1. The Learning from Deaths forum continues to monitor compliance against the Trust Specialty M&M guidance that was agreed and implemented in January 2024.

5.2.2. There is evidence in Datix that Specialty M&M meetings are being held regularly in a number of specialties, including the Stroke and Neurosciences directorate that have established new local Specialty M&M processes in this quarter.

5.2.3. Compliance across the Trust remains low as shown below. Given not all specialties have monthly M&Ms, we will also being to report this data on a 12 month rolling basis going forward.



6. Conclusion

6.1. Mortality rates across the Trust remain statistically significantly low. When considered with our harm profile and the outcomes of our SJRs we can provide assurance to the committee that we are providing safe care for the majority of our patients. Where care issues are found we have a robust process for referral for more in-depth review.

Appendix A – Acute Provider Collaborative performance scorecard

Financial Year	2023-2024			2024-2025	
Financial Quarter	Q2	Q3	Q4	Q1	Q2
No. Deaths	414	445	459	432	379
No. Adult Deaths	392	419	437	412	358
Adult Deaths per 1000 Elective Bed Days	0.04	0.04	0.04	0.03	0.03
No. Child Deaths	5	9	10	7	8
No. Neonatal Deaths	7	9	5	5	8
No. Stillbirths	10	8	7	8	5
ME Reviewed Deaths in Qtr	414	445	459	432	379
% ME Reviewed Deaths - Deaths (excl Stillbirths) in Qtr	100%	100%	100%	100%	100%
SJRs Requested for Deaths in Qtr	67	76	75	51	45
% SJRs Requested for Deaths in Qtr of total adult deaths in Qtr	17%	18%	17%	12%	13%
No. SJRs Completed in period	65	63	84	54	46
SJRs Completed for Deaths in Qtr	67	76	75	51	43
% SJRs Completed for Deaths in Qtr	100%	100%	100%	100%	96%
No. LeDeR Completed	6	4	5	0	1
Requests made by a Medical Examiner - SJRs Requested for Deaths in Qtr	14	7	22	11	8
% Requests made by a Medical Examiner - SJRs Requested for Deaths in Qtr	21%	9%	29%	22%	18%
Concerns raised by family / carers - SJRs Requested for Deaths in Qtr	8	12	6	13	8
% Concerns raised by family / carers - SJRs Requested for Deaths in Qtr	12%	16%	8%	25%	18%
Patients with learning disabilities - SJRs Requested for Deaths in Qtr	6	4	6	5	2
% Patients with learning disabilities - SJRs Requested for Deaths in Qtr	9%	5%	8%	10%	4%
Patients with severe mental health issues - SJRs Requested for Deaths in Qtr	2	1	2	1	2
% Patients with severe mental health issues - SJRs Requested for Deaths in Qtr	3%	1%	3%	2%	4%
Unexpected deaths - SJRs Requested for Deaths in Qtr	37	48	39	17	25
% Unexpected deaths - SJRs Requested for Deaths in Qtr	55%	63%	52%	33%	56%
Elective admission deaths - SJRs Requested for Deaths in Qtr	5	6	6	5	2
% Elective admission deaths - SJRs Requested for Deaths in Qtr	7%	8%	8%	10%	4%
Requests made by speciality mortality leads / through local Mortality and Morbidity review processes - SJRs Requested for Deaths in Qtr	1	1	1	0	0
% Requests made by speciality mortality leads / through local Mortality and Morbidity review processes - SJRs Requested for Deaths in Qtr	1%	1%	1%	0%	0%
Service or diagnosis alarms as agreed by APC mortality surveillance group - SJRs Requested for Deaths in Qtr	0	0	0	0	0
% Service or diagnosis alarms as agreed by APC mortality surveillance group - SJRs Requested for Deaths in Qtr	0%	0%	0%	0%	0%
CESDI 0 - No suboptimal care - Completed SJRs for Deaths in Qtr	55	69	62	44	33
% CESDI 0 - No suboptimal care - Completed SJRs for Deaths in Qtr	82%	91%	83%	86%	77%
CESDI 1 - Some sub optimal care which did not affect the outcome - Completed SJRs for Deaths in Qtr	8	6	7	6	7
% CESDI 1 - Some sub optimal care which did not affect the outcome - Completed SJRs for Deaths in Qtr	12%	8%	9%	12%	16%
CESDI 2 - Suboptimal care – different care might have made a difference to outcome (possible avoidable death) - Completed SJRs for Deaths in Qtr	3	1	6	1	3
% CESDI 2 - Suboptimal care – different care might have made a difference to outcome (possible avoidable death) - Completed SJRs for Deaths in Qtr	4%	1%	8%	2%	7%
CESDI 3 - Suboptimal care - would reasonably be expected to have made a difference to the outcome (probably avoidable death) - Completed SJRs for Deaths in Qtr	1	0	0	0	0
% CESDI 3 - Suboptimal care - would reasonably be expected to have made a difference to the outcome (probably avoidable death) - Completed SJRs for Deaths in Qtr	1%	0%	0%	0%	0%

Appendix B – Ethnicity data

	North West London		Ethnicity breakdown of all inpatient encounters in the Trust	Cerner data		Combined data set (WSIC and Cerner)		Difference (Combined-Cerner)	
	2021 Census data		2023/2024	2024/2025		2024/2025			
Ethnicity	**Population**	**% population**		**No. Deaths**	**% Deaths**	**No. Deaths**	**% Deaths**	**No. Deaths**	**% Deaths**
Totals	**2,092,995**	**100.00%**	**100%**	**730**	**100.00%**	**730**	**100.00%**	**0**	**0.00%**
Asian - Any Other Asian Background	154,465	7.38%	6.30%	32	4.40%	36	4.90%	4	0.50%
Asian or Asian British - Bangladeshi	24,738	1.18%	0.86%	5	0.70%	4	0.50%	-1	-0.10%
Asian or Asian British - Indian	329,149	15.73%	6.98%	46	6.30%	61	8.40%	15	2.10%
Asian or Asian British - Pakistani	79,645	3.81%	2.44%	12	1.60%	22	3.00%	10	1.40%
Black - Any Other Black Background	23,316	1.11%	2.85%	11	1.50%	9	1.20%	-2	-0.30%
Black or Black British - African	125,609	6.00%	6.05%	18	2.50%	24	3.30%	6	0.80%
Black or Black British - Caribbean	64,165	3.07%	4.29%	42	5.80%	58	7.90%	16	2.20%
Mixed - Any Other Mixed Background	38,560	1.84%	1.94%	4	0.50%	7	1.00%	3	0.40%
Mixed - White and Asian	30,428	1.45%	0.70%	3	0.40%	5	0.70%	2	0.30%
Mixed - White and Black African	15,927	0.76%	0.69%	2	0.30%	1	0.10%	-1	-0.10%
Mixed - White and Black Caribbean	23,379	1.12%	0.84%	3	0.40%	6	0.80%	3	0.40%
Other - Any Other Ethnic Group	109,126	5.21%	10.74%	111	15.20%	86	11.80%	-25	-3.40%
Other - Chinese	31,268	1.49%	1.06%	3	0.40%	0	0.00%	-3	-0.40%
Other - Not Known	n/a	n/a	0.46%	28	3.80%	21	2.90%	-7	-0.90%
Other - Not Stated	n/a	n/a	7.62%	98	13.40%	46	6.30%	-52	-7.10%
White - Any Other White Background	344,734	16.47%	18.07%	75	10.30%	104	14.20%	29	4.00%
White - British	563,903	26.94%	25.48%	208	28.50%	207	28.40%	-1	-0.10%
White - Irish	44,291	2.12%	2.63%	29	4.00%	36	4.90%	7	1.00%
Arab	77,548	3.71%	These ethnic groups are not recorded within the NHS as they are not part of the organisational data set						
Gypsy Or Irish Traveller	1,665	0.08%							
Roma	11,079	0.53%							

NWL Acute Provider Collaborative Board in Common (Public)
21/01/2025
Item number: #
This report is: Public

London North West University NHS Trust Learning from Deaths Report Quarter 2 2024/25

Author: Laila Gregory
Job title: Head of Clinical Effectiveness

Accountable director: Jon Baker
Job title: Chief Medical Officer

Purpose of report

Purpose: Assurance

This report presents the data from the Learning from Deaths programme for 2024/25 quarter 2 (Q2). It is a statutory requirement for Trusts to present this information to their boards; this is achieved through the presentation of this report to the LNWH Quality & Safety Committee and the submission of overarching learning drawn from across the acute provider collaborative (APC) to the APC Quality Committee and Board in common.

Report history

Learning from Patient Deaths Group	Trust Executive Group	Quality & Safety Committee
26-Nov-24	20-Nov-24	25-Nov-24

Executive summary and key messages

The Trust is the 7th best performing acute (non-specialist) provider in England in terms of relative risk of mortality with a Trust-wide SHMI of 0.86 (where a number below 1 is better than expected mortality) for period June 2023 – May 2024. This positive assurance is reflected across the Trust as the main sites continue to operate below the expected relative risk of mortality.

During the 12-month period to end of September 2024; 100% in-hospital adult and child deaths were recorded within the Trust's mortality review system (Datix), of these 99% have been screened and 323 have undergone level 2 in-depth review.

During Q2 2024/25; 26 cases with areas of sub-optimal care, treatment or service delivery have been identified at time of reporting. The Trust places significant value on case discussion and learning undertaken within specialty and divisional multi-disciplinary teams; for this reason teams are given 4 months to complete level 2 mortality review, therefore 15% of cases occurring in Q2 remain open and within review timeframe.

Where potential for improvement is identified learning is shared at Divisional Boards / groups and presented to the Trust-wide Learning from Patient Deaths Group; this ensures outcomes are shared and learning is cascaded.

Strategic priorities

Tick all that apply

☐ Achieve recovery of our elective care, emergency care, and diagnostic capacity
☐ Support the ICS's mission to address health inequalities.
☐ Attract, retain, develop the best staff in the NHS
☒ Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation.
☐ Achieve a more rapid spread of innovation, research, and transformation.

Improving how we learn from deaths which occur in our care will support identification of improvements to quality and patient outcomes.

Impact assessment

Tick all that apply

☐ Equity
☒ Quality
☐ People (workforce, patients, families or careers)
☐ Operational performance
☐ Finance
☐ Communications and engagement
☐ Council of governors

Mortality case review following in-hospital death provides clinical teams with the opportunity to review expectations, outcomes and learning in an open manner. Effective use of mortality learning from internal and external sources provides enhanced opportunities to reduce in-hospital mortality and improve clinical outcomes and experience for patients and their families.

2. Learning and Improvements

The Trust's Mortality Surveillance programme offers assurance to our patients, stakeholders, and the Board that high standards of care are being provided and that any gaps in service delivery are being effectively identified, escalated, and addressed. This report provides a Trust-level quarterly review of mortality learning for Q2 2024/25.

All in-hospital deaths are scrutinised by the Trust's Medical Examiner Service; this initial screening provides an independent review of care and is the basis for triggering cases for enhanced (level 2) review by the Consultant Mortality Validators and the specialities involved.

The Trust undertakes in-depth (level 2) mortality review for cases meeting the following criteria:

National triggers:
- Potential learning identified at Medical Examiner scrutiny.
- Significant concerns raised by the bereaved.
- Deaths of patients with learning disability
- Deaths of patients under a mental health section
- Unexpected deaths
- Maternal deaths
- Deaths of infants, children, young people, and still births
- Deaths within a specialty or diagnosis / treatment group where an 'alarm' has been raised (e.g. via the Summary Hospital-level Mortality Indicator or other elevated mortality alert, the CQC or another regulator)

Local triggers:
- Deaths post elective surgery (at most recent admission)
- Deaths accepted by the Coroner for inquest / investigation.

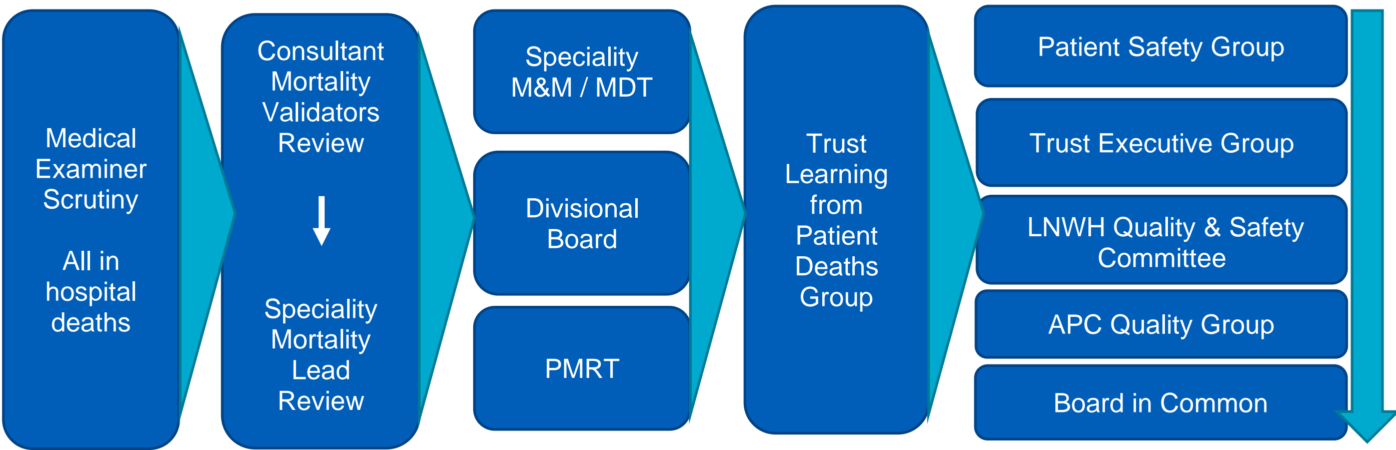
During Q2 2024/25 deaths accepted by the coroner for inquest or investigation were added to the Trust's local trigger list for in-depth (level 2) review by the Trust's Consultant Mortality Validators and the specialities providing care to the patient (as required). This addition has supported the identification of learning opportunities, providing enhanced assurance to the Trust and the bereaved, and support the Coroner's inquest processes.

The addition of this local trigger has resulted in an additional 58 cases requiring in-depth review as at end of September, however, review completion performance remains strong.

2023-24		2024-25	
Q3	Q4	Q1	Q2
97%	92%	89%	85%

Tab 1: Percentage of completed level 2 reviews by quarter

The Learning from Patient Deaths Group (LfPDG) challenges assurance regarding performance and outcomes from the Trust's learning from deaths approach as outlined below:



The Learning from Patient Deaths Group (LfPDG) provides leadership to this programme of work and is supported by standing items on relative risk of mortality, potential learning from medical examiners, learning from inquests, and divisional learning from mortality review. The LfPDG is a sub-group of the Patient Safety Group and is aligned to the remit of the Quality and Safety Committee.

3. Relative Risk

The Trust uses the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) to monitor the relative risk of mortality. Both tools are used to determine the relative risk of mortality for each patient and then compare the number of observed deaths to the number of expected deaths; this provides a relative risk of mortality ratio.

Population demographics, hospital service provision, intermediate / community service provision has a significant effect on the numbers of deaths that individual hospital sites should expect; the SHMI and HSMR are designed to reduce this impact and enable a comparison of mortality risk across the acute hospital sector. By monitoring relative risk of mortality, the Trust is able to make comparisons between peer organisations and seek to identify improvement areas where there is variance.

3.1. Summary Hospital-level Mortality Indicator (SHMI)

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI calculation includes 100% of in-hospital deaths (excluding still-births) and those deaths that occur within 30 days of discharge. The SHMI is composed of 144 different diagnosis groups and these are aggregated to calculate the overall SHMI value for each organisation.

The Trust is the 7th best performing acute provider in England in relation to the SHMI relative risk of mortality indicator. The Trust-wide SHMI for the period June 2023 – May 2024 is 0.8605 (where a number below 1 represents lower than expected risk of mortality).

North West London Acute Collaborative SHMI indicators

Trust	SHMI	Observed Deaths	Expected Deaths	Provider Spells	% mortality: elective admission	% mortality: Palliative care coding	% mortality: 30 days post discharge
LNWH	0.86	2,720	3,160	106,780	0.0%	40%	27%
CWH	0.69	1,685	2,445	100,475	0.0%	51%	24%
ICH	0.73	2,115	2,900	112,015	0.0%	65%	24%
THH	0.98	945	960	46,465	0.0%	56%	27%

Tab 2, Data Source: NHS England, SHMI, June 2023 – May 2024, published 10/10/2024.

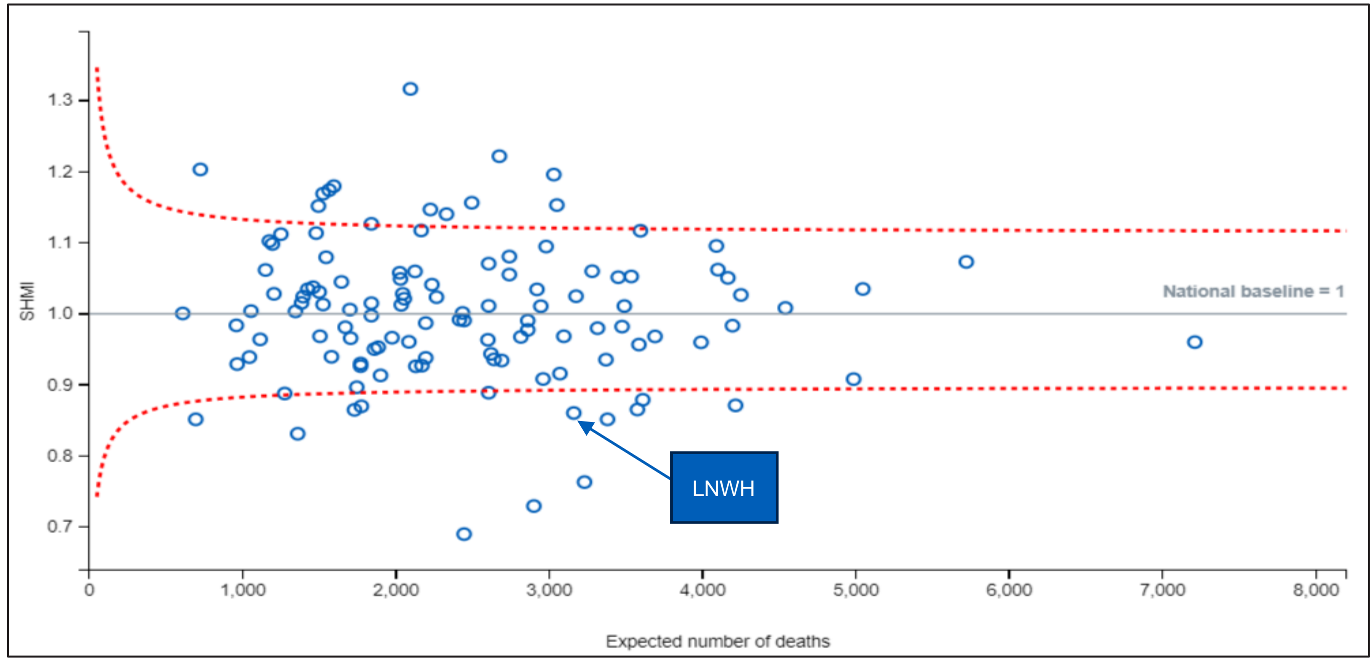


Fig 1 – SHMI, NHS England acute hospital Trusts June 2023 – May 2024, published 10/10/2024.

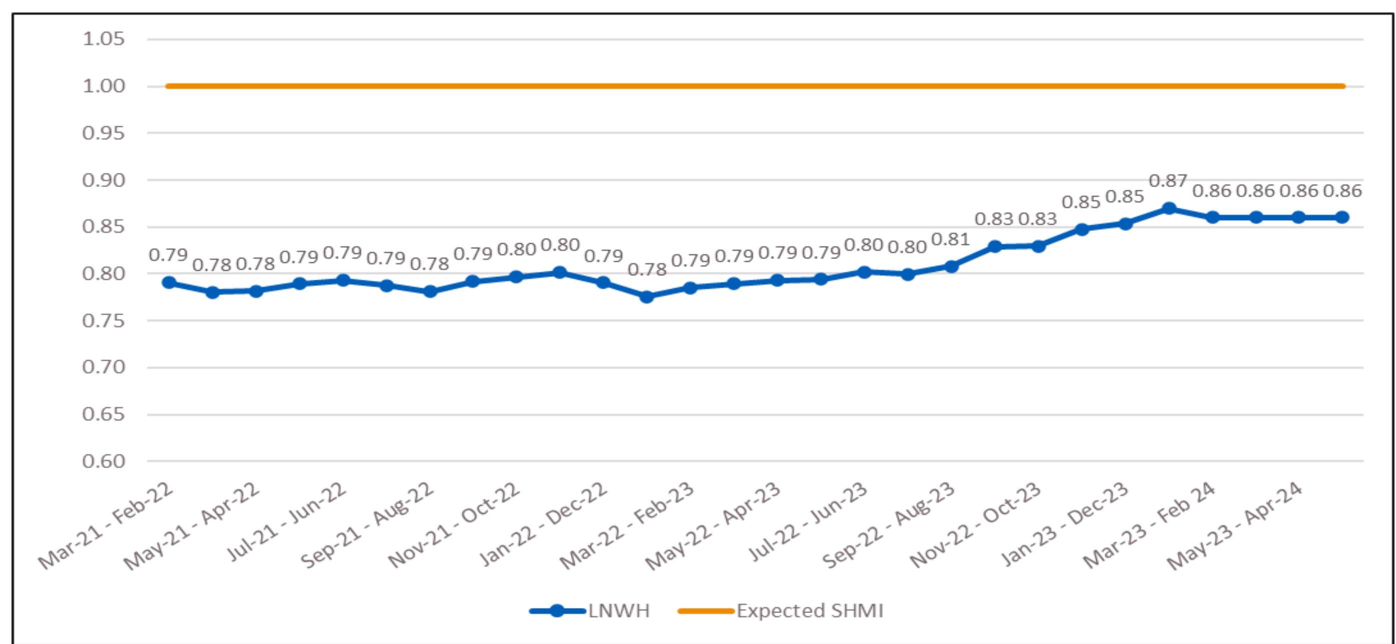


Fig 2 – Trust wide SHMI by reporting period, March 2021 to May 2024.

This positive assurance is reflected across the Trust as the organisation's principal sites continue to operate below the nationally expected relative risk of mortality:

- Northwick Park Hospital: 0.88 (2,115 expected, 1,865 observed, 76,875 provider spells)
- Ealing Hospital: 0.73 (980 expected, 710 observed, 25,875 provider spells)
- St. Marks Hospital: SHMI value 'not calculated' (35 expected, 25 observed, 685 provider spells)
- Central Middlesex Hospital: SHMI value 'not calculated' (20 expected, nil observed within latest SHMI calculation, 3,060 provider spells).

3.1.1. SHMI Diagnostic groups

The SHMI is made up of 142 different diagnostic groups which are then aggregated to calculate the Trust's overall relative risk of mortality. The Learning from Patient Deaths Group monitors expected and observed deaths across diagnostic groups; where statistically significant variation is identified the group undertakes coding and care review to identify any themes or potential improvement areas.

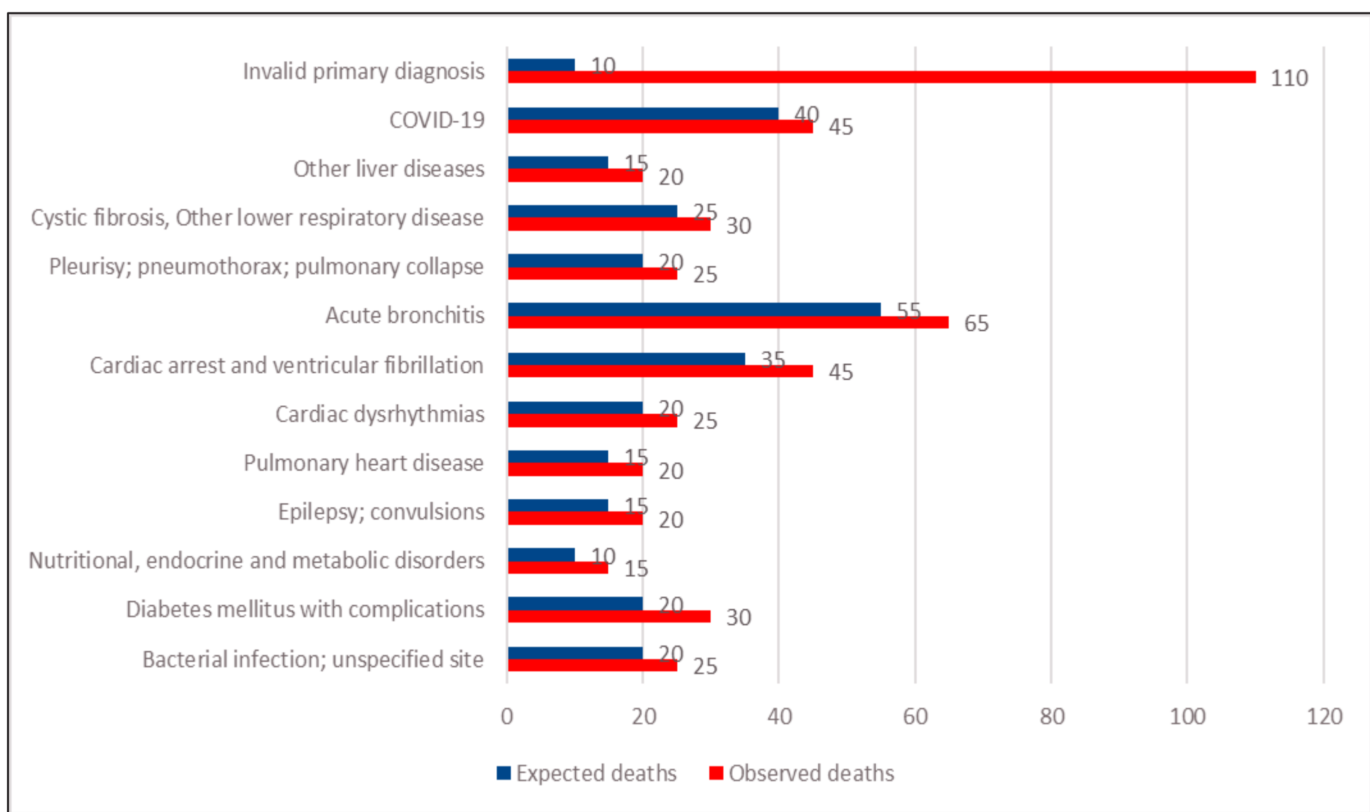


Fig 4: Expected deaths greater than observed deaths by diagnostic group, SHMI comparison of England acute hospital Trusts June 2023 – May 2024, published 10/10/2024.

During Q2 24/25 the Learning from Patient Deaths Group (LfPDG) considered diagnostic groups with higher observed deaths than expected, the group took assurance that that relative risk within these diagnostic groups remained below or within the expected range (no alerts) but considered the need for further clinical or coding review to support the identification of improvement opportunities.

Invalid primary diagnosis – the coding of primary diagnosis impacts the SHMI and HSMR calculation. Within the June 2023 – May 2024 SHMI calculations 0.3% of the Trust's provider spells contained an invalid primary diagnosis as compared with the national average of 1.6%. Additionally, 15% of spells included a symptom or sign rather than a defined primary diagnosis (as compared with the national average of 13.8%). The organisation's coding team have highlighted difficulties capturing primary diagnosis from clinical notes. During Q3 2024/25 the organisation's mortality review database is being amended to confirm primary diagnosis information with the reporting doctor as part of the medical examiner discussion; this will support improvement of this metric for deceased patients.

Cardiac arrest and ventricular fibrillation: clinical review of cases linked to this diagnostic group were undertaken during Q4 2023/24, this review concluded higher observed deaths were primarily linked to out of hospital cardiac arrests with appropriate treatment and escalation to ITU as required. No deficiencies in care were identified during this review. The LfPDG took assurance from this review and determined that further examination was not required during Q2 2023/24.

Acute Bronchitis: the latest SHMI publication (October 2024) identifies a small increase in deaths linked to diagnostic group acute bronchitis. During this 12 month reporting period (June 2023 – May 2024) there were 2,035 provider spells associated with this primary diagnostic group and 65 observed deaths as compared with 55 expected. The LfPDG is to review this publication and determine its learning response at its next sitting.

3.2. Hospital Standardised Mortality Ratio (HSMR)

The HSMR compares the number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on the type of cases treated. The HSMR calculation includes 80% of in-hospital deaths (including still-births); it excludes deaths post discharge and cases with palliative care coding.

Based on the 56 top diagnostic groups the Trust's HSMR for period August 2023 to July 2024 is 93.1 (where a number below 100 represents lower than expected risk of mortality).

North West London Acute Collaborative HSMR based on top 56 diagnostic groups:

Trust	HSMR	Observed Deaths	Expected Deaths	Volume
LNWH	93.1	1571	1687	57,861
CWH	82.0	1,070	1,305	53,835
ICH	72.8	1,380	1,897	74,805
THH	92.0	575	624	21,885

Tab 3: Data Source: Telstra, HSMR (56 diagnostic groups) by APC provider, August 2023 – July 2024

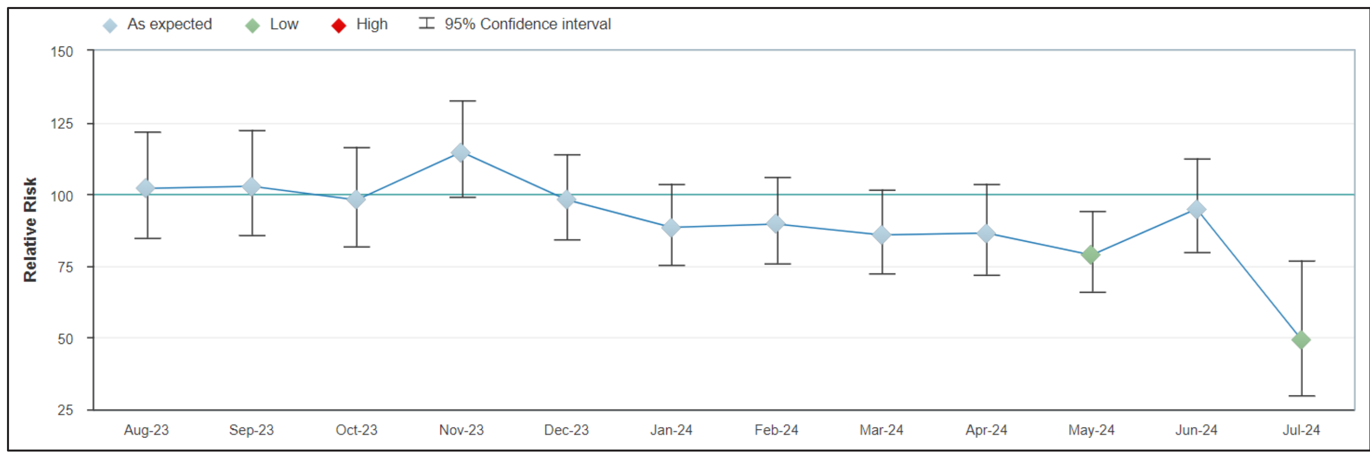


Fig 3: Data Source: Telstra, HSMR trend (56 diagnostic groups), August 2023 – July 2024

The most recent data available shows that the Trust continues to operate below the expected relative risk of mortality based on HSMR trend for the top 56 diagnostic groups.

3.2.1. HSMR Diagnostic groups

During Q2 2024/25, the Learning from Patient Deaths Group faced limitations in their ability to scrutinise HSMR diagnostic categories with higher-than-expected mortality rates due to the expiration of the Trust's contract with Telstra Health UK, formerly known as Dr Foster. This contract was renewed in October 2024. HSMR learning and alerts will be provided to subsequent sitting of the Learning from Patient Deaths Group.

The following diagnostic groups indicate higher than expected relative risk of mortality:

Diagnostic group alerts	Volume	Observed	Expected	Relative risk
Residual codes, unclassified	98,353	1194	1278	172.6
Cardiac arrest and ventricular fibrillation	57	40	28.4	140.7
Diabetes mellitus with complications	995	23	13.0	177.3
Immunity disorders	36	1	0	10513
Nephritis, nephrosis, renal sclerosis	811	5	2.9	175.1
Other nutritional, endocrine, and metabolic disorders	1220	10	7.2	138.5

Tab 4: Data Source: Telstra, Diagnostic groups with CUMSUM alerts, August 2023 – July 2024

The appropriate response to these diagnostic group alerts will be determined by the Learning from Patient Deaths Group; learning / outcomes will be described within the Trust's Q3 update.

4.0 Crude Mortality

Acute activity and the crude number of deaths occurring during that reporting activity can be used to calculate the rate of in-hospital deaths per 1,000 patient spells (this calculation excludes elective and obstetric activity).

Crude mortality rates must not be used to make comparisons between sites due to the effect that population demographics, services offered by different hospitals, and services offered by intermediate / community care has on health outcomes (e.g. crude mortality does not consider the external factors that significantly influence the relative risk of mortality at each site). Crude mortality is useful to inform resource allocation and strategic planning.

The following crude rates include only adult acute admitted spells by age band (>17). This approach is used as it reduces some of the variation when comparing sites and supports understanding and trend recognition undertaken by the Learning from Patient Deaths Group.

Trust wide – Adults, crude mortality rate per 1000 acute admissions (adults)

Acute activity (adult) | Adult deaths per 1000

Fig 5 – Crude mortality rate per 1000 acute admissions, Trust wide

Northwick Park Hospital – Adults, crude mortality rate per 1000 acute admissions (adults)

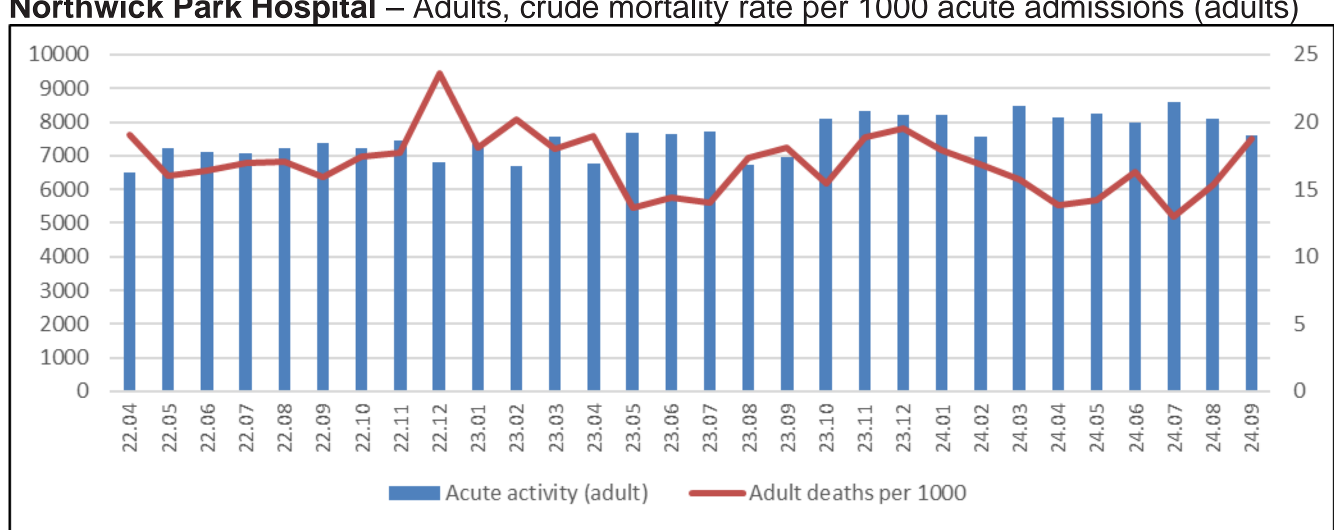


Fig 6 – Crude mortality rate per 1000 acute admissions, NPH

Ealing Hospital – Adults, crude mortality rate per 1000 acute admissions (adults)

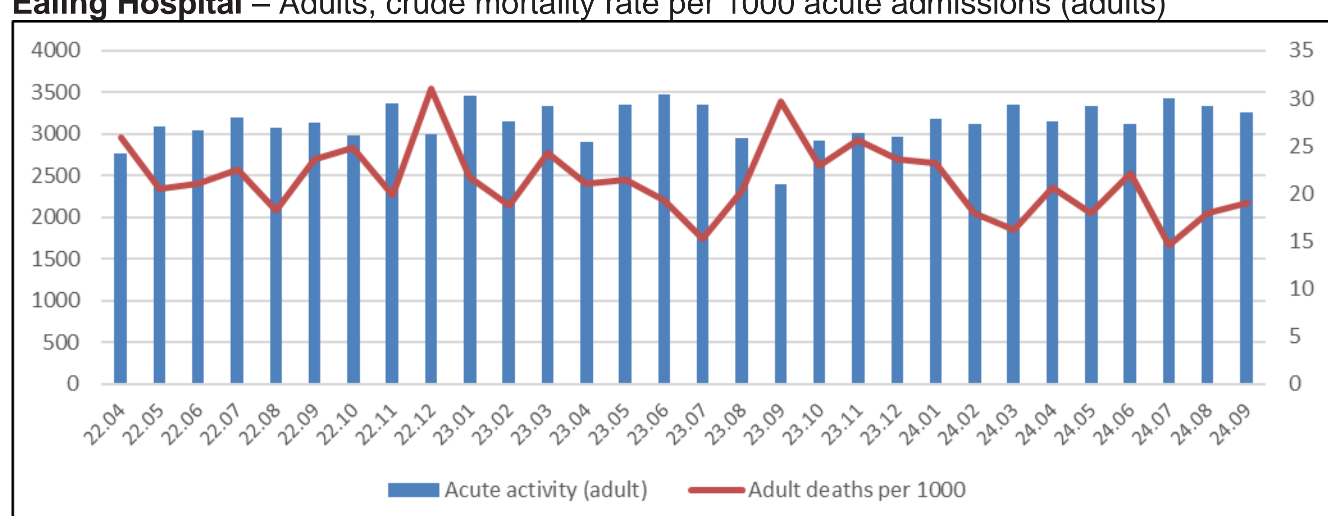


Fig 7 – Crude mortality rate per 1000 acute admissions, EH

5.0 Mortality review

5.1 Medical Examiner's Service

The Medical Examiner's Service provides enhanced scrutiny to all in-hospital deaths, supports the identification of potential learning, and offers a point of contact for bereaved families wishing to raise concerns. The functions of this service are to:

- Provide greater safeguards to the public by ensuring scrutiny of all non-coronial deaths.
- Ensure the appropriate direction of deaths to the coroner.
- Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased.
- Improve the quality of death certification.
- Improve the quality of mortality data.

During Q2 2024/25 the service scrutinised 549 (99%) in-hospital deaths, this resulted:

- 113 cases referred to the coroner of which; 25 were retained for investigation, 44 were returned for certification with no requirement for further coroner investigation
- 42 cases with potential learning for the Trust, triggering in-depth (level 2) mortality reviews.

In addition, the service scrutinised 273 community deaths (199 from GP practices, and 74 from local Hospices and a further 3 were referred to the coroner). The service currently receives referrals from 68% of local GP practices.

Achievements: the service has achieved the transition to the new statutory service under the Medical Examiners (England) Regulations 2024. With scrutiny of referred deaths within the required timelines. The service has the highest percentage of 24-hour releases across the sector, when requested for reasons of religious observance.

Challenges: this quarter has seen the statutory reporting of all community deaths to the Medical Examiner Service, other than clear Coronial referrals. The volume of work has increased significantly. The changes in statute also now require a Medical Examiner to countersign every medical certificate of cause of death (MCCD) which has multiplied the number of steps needed to issue an MCCD. The service is now also required to be involved in a more detailed review of community deaths where bereaved relatives have concerns about care. This can result in a prolonged discussion with several parties.

There has also been a change in the way HM Coroners respond to referrals of deaths in the community that appear not to be unnatural or violent, but where no cause of death is known; these are now referred back to the GP in order that the GP can then refer to the Medical Examiner Service for further scrutiny before being referred back to HM Coroner.

Improvements: while there has been no change in staffing, the service has moved from an on-call Medical Examiner system at weekends, to a shift system for both Medical Examiners and Medical Examiner Officers. The additional cost has been minimal and was mostly achievable through current external funding, making the service a leader in the sector. The service is in the process of setting up a pilot to use Band 2/3 Agenda for Change staff to deal with the increased number of telephone enquiries being received from the relatives of those who died in the community.

5.2 In-depth (level 2) mortality review

Mortality case review provides clinical teams with the opportunity to review expectations, outcomes and potential improvements with the aim of:

- Identifying sub-optimal or excellent care
- Identifying service delivery problems
- Developing approaches to improve safety and quality
- Sharing concerns and learning with colleagues

Learning from review is shared at specialty mortality review groups (M&Ms / MDTs); where issues in care, trends or notable learning is identified action is steered through the Divisional Quality Boards / Governance Groups and the Trust-wide Learning from Patient Deaths Group (LfPDG).

During the 12-month period October 2023 to September 2024, 2,376 in-hospital adult or child deaths were recorded within the Trust's mortality review system (Datix), of these 99% have been

screened. Screening identified 359 (15%) cases that would benefit from in-depth (level 2) review. Of these 90% have completed this in-depth review process, which represents a 7% increase since the last quarterly report.

	No. of deaths	No. of cases screened	No. of cases flagged for level 2 review	No. case with completed level 2 review	% cases Screened	% of level 2 reviews completed
Q3 23/24	665	665	77	75	100%	**97%**
Q4 23/24	595	595	64	59	100%	**92%**
Q1 24/25	560	560	83	74	100%	**89%**
Q2 24/25	556	549	135	115	99%	**85%**
Totals	**2,376**	**2,369**	**359**	**323**	**99.7%**	**90%**

Tab 3: Adult & child mortality review status by financial quarter, October 2023 – September 2024

The Consultant Mortality Validators undertake level 2 in-depth mortality reviews and identify cases that need Speciality Mortality Leads to conduct their own level 2 in-depth reviews. Speciality Mortality Leads have 4 months from the date of death to complete these reviews. Compliance is monitored by the Divisional Boards / Governance meeting, Learning from Patient Deaths Group, and overseen by the Trust Executive Group and Quality & Safety Committee.

Hospitals	No. of deaths	No. of cases screened	No. of cases flagged for level 2 review	No. case with completed level 2 review	% cases Screened	% of level 2 reviews completed
Northwick Park & St Marks	1,605	1,598	249	225	99%	**90%**
Ealing	767	767	108	97	100%	**90%**
Central Middlesex	4	4	2	1	100%	**50%**
Totals	**2,376**	**2,369**	**359**	**323**	**99.7%**	**90%**

Tab 4: Adult & child mortality review status by site, October 2023 – September 2024

The following key trends arising from process compliance monitoring have been noted:

- The percentage of in-patient deaths identified for in-depth review (level 2) has increased again this quarter from 15% in Q1 2024/25 to 24% in Q2 2024/25. This upward trend is attributed to the change in local triggers for a level 2 review, which includes all cases accepted for coroner's investigation and those that have an inquest.

- 'Unexpected death' remains the most frequent trigger for in-depth mortality review at 38% (51 cases), followed by 'medical examiner concerns' 31% (42 cases). Medical examiners concerns have continued to rise since Q4 2023/24 each quarter and a review is being undertaken to ensure that the service has is utilising triggers appropriately. Initial findings show that the service may need additional changes made to the system to separate out their concerns from national/local triggers.

- 115 in-depth mortality reviews relating to deaths occurring during Q2 2024/25 have been undertaken at time of reporting; 77% of which identified no sub-optimal care (CESDI Grade 0), which is the same rase as the previous quarter (Q1 2024/25).

The Divisional Mortality Leads provide scrutiny to mortality cases so as to; identify themes and escalate any issues of concerns. Key themes / issues identified via mortality review this quarter:

- **Documentation and Communication**: Need for better recording of discussions with Next of Kin, which has been enhanced through the use of Cerner but there is still work to be undertaken.

- **Role of Nursing in Family Engagement**: there is a need to increase the involvement of nursing teams when addressing family concerns with patient care.

- **Collaboration with Palliative Care**: Increasing positive evidence of joint working with Palliative Care teams to enhance patient care. Good utilisation of Treatment Escalation Plans (TEP) which improve decision-making for end-of-life care.

- **Advanced Care Planning for Elderly Patients**: need for proactive ceiling of care decisions and advanced care planning. Ongoing challenges in accessing community-based planning documentation within the hospital.

- **Follow-up of Investigation Results**: teams discussed the emphasis being placed on the responsibility of clinicians to follow up investigation results. The importance of timely assessment of transferred patients and ongoing care planning.

- **Addressing Language Barriers:** recognition of the need to improve access to emergency treatment and care for non-English speakers, through trust-wide initiatives.

6.3 CESDI Grading of Care

Outcome, avoid ability and / or suboptimal care provision is defined using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categories that have been adopted by the Trust for use when assessing deaths:

- Grade 0: No suboptimal care or failings identified, and the death was unavoidable.
- Grade 1: A level of suboptimal care identified during hospital admission, but different care or management would NOT have made a difference to the outcome and the death was unavoidable.

- Grade 2: Suboptimal care identified, and different care MIGHT have made a difference to the outcome, i.e. the death was possibly avoidable.
- Grade 3: Suboptimal care identified, and different care WOULD REASONABLY BE EXPECTED to have made a difference to the outcome, i.e. the death was probably avoidable.

CESDI grades October 2023 – September 2024

Period	CESDI 0	CESDI 1	CESDI 2	CESDI 3
Q3 23/24	56	16	3	0
Q4 23/24	41	15	3	0
Q1 24/25	57	13	4	0
Q2 24/25	89	24	2	0
Total	243	68	12	0

Tab 5: Closed mortality cases by CESDI grade, October 2023 to September 2024

During this 12-month period 12 cases of sub-optimal care that might have made a difference to the patient's outcome (CESDI 2) and 0 cases where sub-optimal care would reasonably be expected to have made a difference to outcome were identified. All cases graded as CESDI 2 or 3 are presented to the Trust's Emerging Incident Review Group for confirmation of learning response (e.g. SI / PSII).

The graph below illustrates the distribution of CESDI grades across the three sites, reflecting the nature of events being reviewed by Mortality Leads. Northwick Park has the highest number of sub-optimal care with 52 cases, followed by Ealing with 27 cases and Central Middlesex with 1 case. This graph suggests that the majority of cases where different care might have made a difference to outcome were equally distributed.

CESDI Grades by Site between October 2023 – September 2024

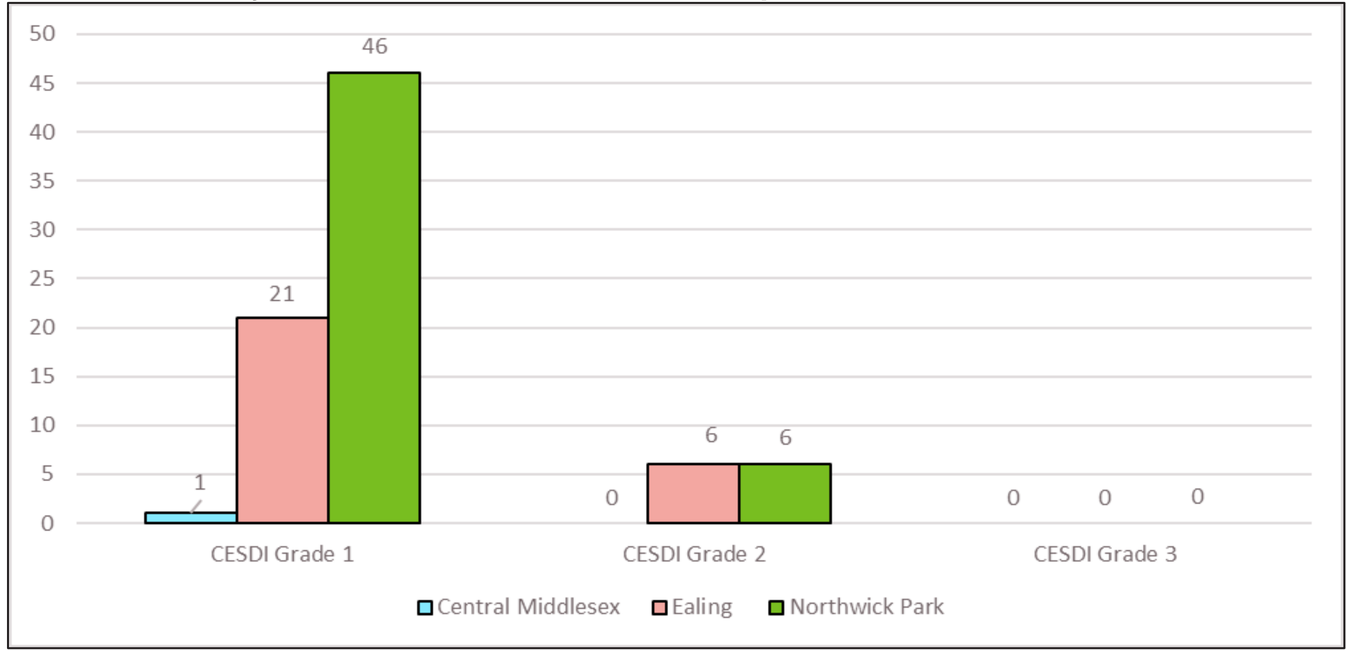


Fig 8 – CESDI Grade by Site, October 2023 to September 2024

6.0 Ethnicity & Gender

The ethnicity data shows a consistent picture in terms of the proportion of deaths by ethnicity during Q2 2024/25. Further analysis by ethnicity is provided in appendix B.

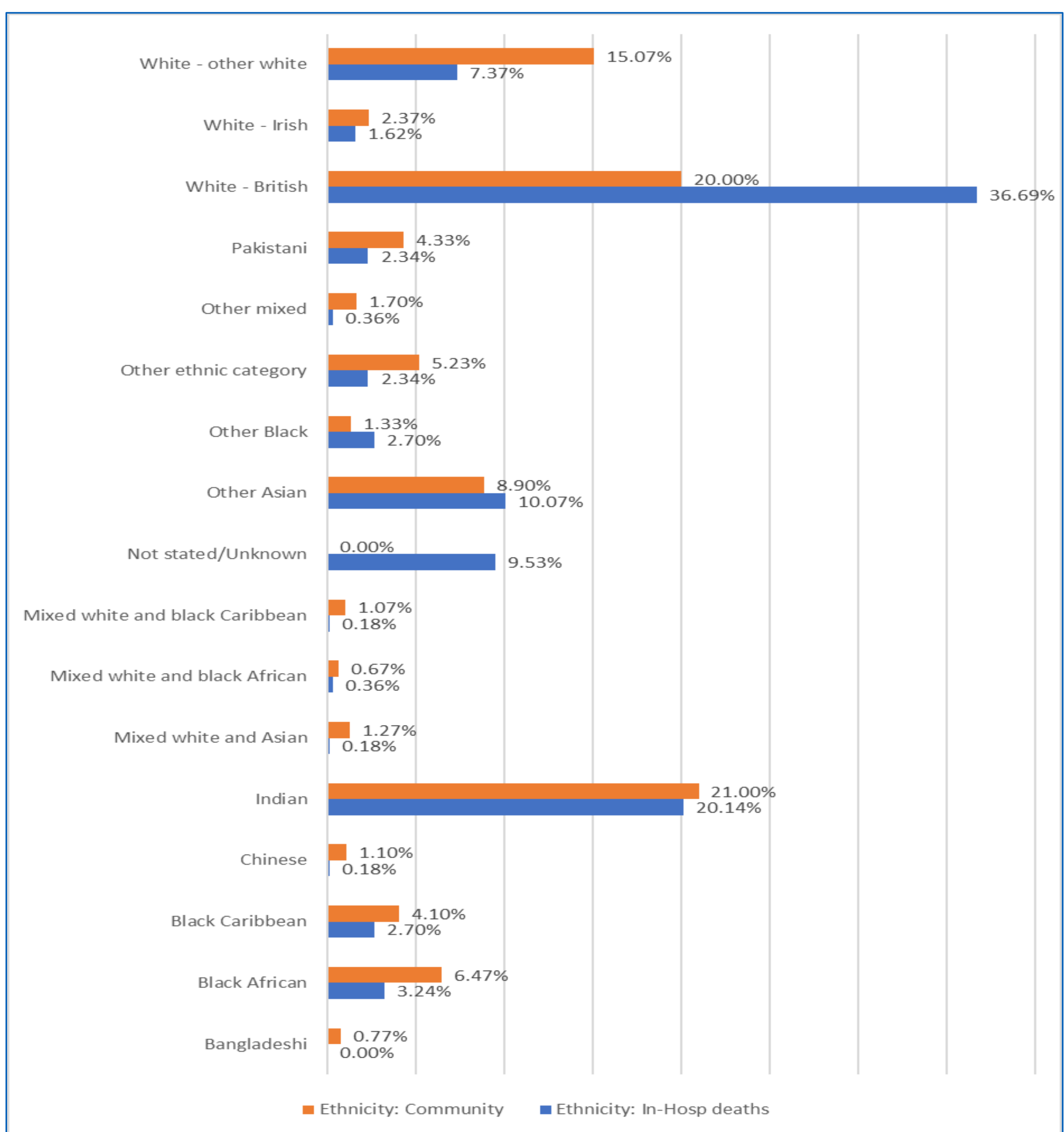


Fig 9 – Ethnicity breakdown, Q2 2024/25

White British remains is the most frequently identified ethnicity associated with in-hospital mortality, account for 36.9% of deaths occurring during Q2 20204/25. It is noted that the local populations of Brent, Ealing, Harrow recognises 20% of the population as this ethnicity. This suggests a higher rate of in-hospital deaths compered to community deaths for this group. Indian

remains the second most frequent ethnicity associated within in-hospital death at 20.14%, while being the biggest identified population for these boroughs at 21%.

As in the previous 12-month period, the CESDI Grade 1 cases predominantly involve individuals of Indian ethnicity followed by White British. With a similar pattern observed for CESDI Grade 2 cases. These findings align with the demographic composition of the population in Brent, Ealing, and Harrow, where Indian and White British groups are the largest resident populations.

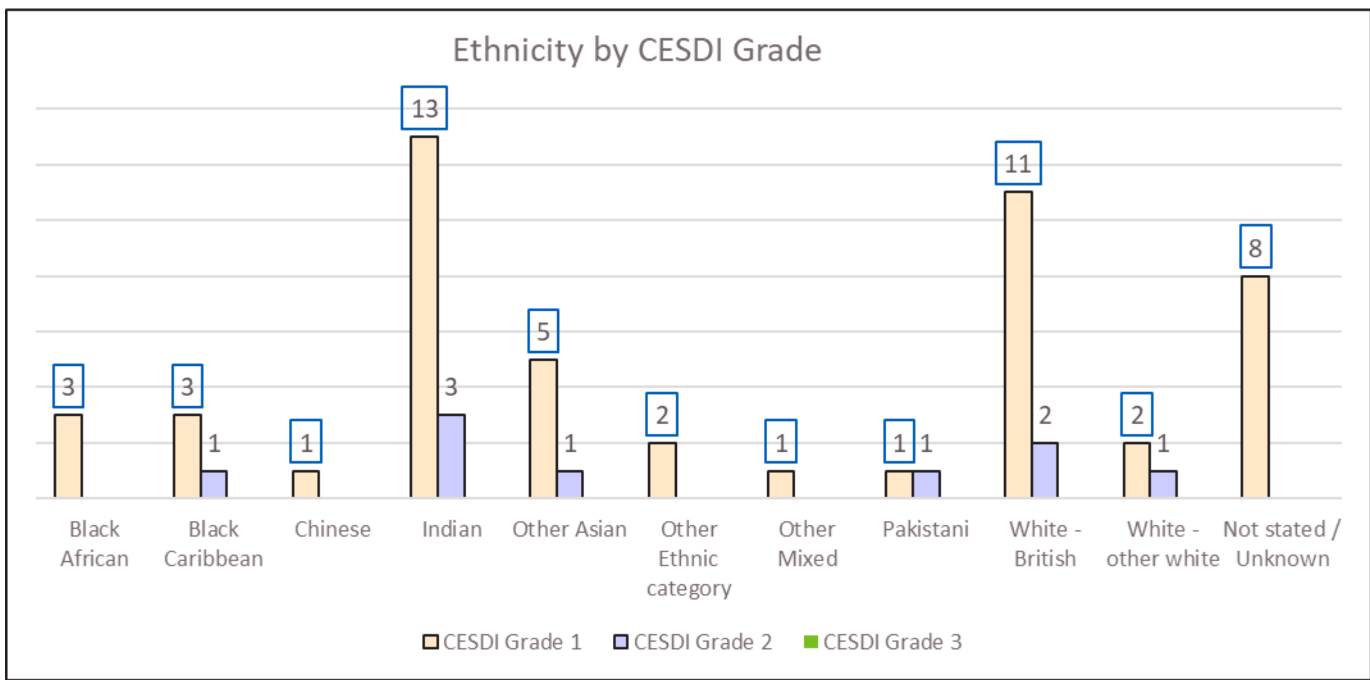


Fig 10: Closed mortality cases by CESDI grade and Ethnicity, October 2023 – September 2024

Analysis of CESDI grades by gender indicates the same trend as is the previous 12 month period, that the care of male patients is more likely to have elements of sub-optimal care identified than female patients.

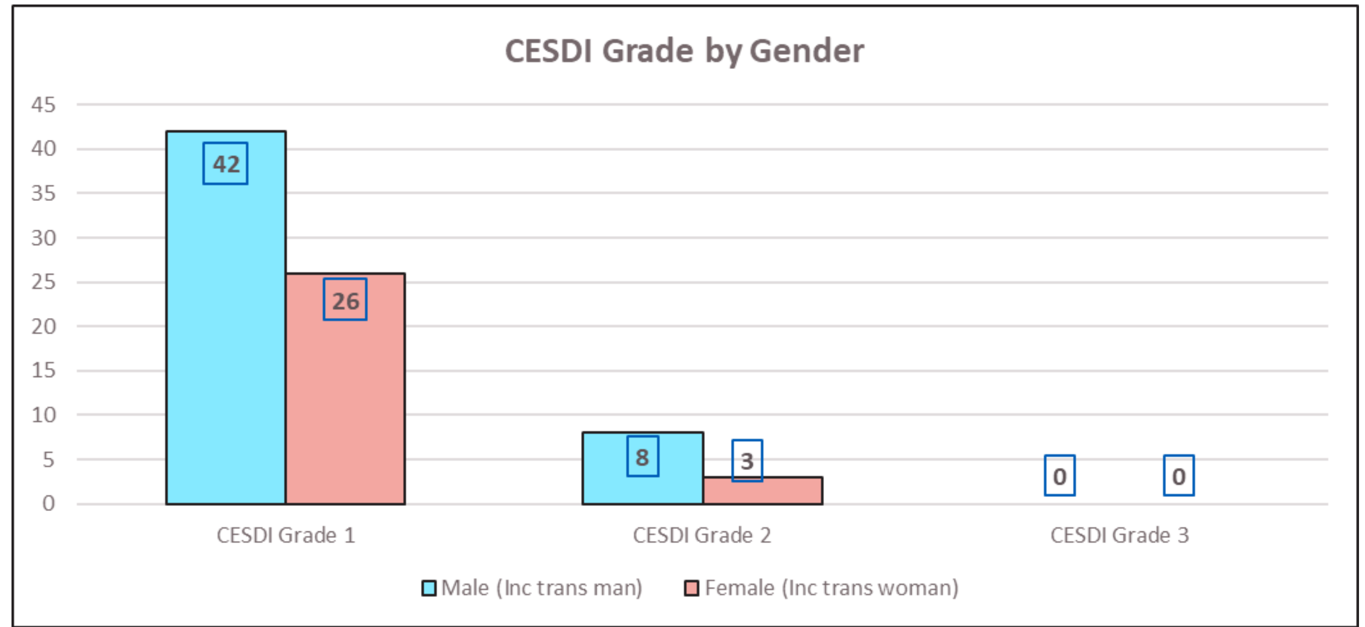


Fig 11: Closed mortality cases by CESDI grade and Gender, October 2023 – September 2024

7.0 Child Death Overview Panels

Overview: There were a total 2 child deaths across Brent, Ealing & Harrow Borough resident children and young people during Q2 2024/25:

- Harrow: 1
- Ealing: 1
- Brent: 0

Case 1: 10-year-old, known to the Oncology Team, receiving symptom care at GOSH, Noah's Ark and from the Paediatric Team. Multiple admissions recently, admitted with fever, cough and vomiting symptoms. Noted to be declining and after discussions with parents, patient was palliated on buccal and NG medication.

Case 2: 4-year-old, with a background of cerebral palsy, hypoxic ischaemic encephalopathy, epilepsy, dystonia and unsafe swallow (PEG J fed). Child was BIBA as cardiac arrest call (initially a blue call) having been found by parents looking blue and unresponsive. London Ambulance Service commenced CPR and patient brought into ED, where 4 cycles of CPR were undertaken. Patient had rigor mortis and trismus, and a decision was made to stop, the parents were informed.

Challenges: no challenges identified in either case.

Improvements Made: Case 1, No improvement recommendations identified, the team continue to deliver good collaborative work across the different sites/trusts that help to support children with oncological needs, needing palliative care. Case 2: care was managed well from arrival in ED, with the whole team working together. Resus documentation to include observations and body map post death, these are not yet recordable on Cerner. JAR held, trust should aim to record decisions around coroner referral or PM on Cerner.

8.0 Perinatal Mortality Review Tool

Overview: The Perinatal Mortality Review Tool (PMRT) is a national mandatory monitoring and assurance dataset developed by MBRRACE-UK. It is used to collect very detailed information about the care mothers and babies have received throughout pregnancy, birth and afterwards. The purpose of the PMRT is to support hospital learn from deaths by providing a standardised and structured review process. The PMRT is designed to support review of:

- All late fetal losses (22 weeks + 0 days to 23 weeks + 6 days).
- All antepartum and intrapartum stillbirths.
- All neonatal deaths from birth at 22 weeks + 0 days to 28 days after birth

During Q2 2024 the following cases were reviewed:

July 2024:

- No fetal losses, stillbirths, or neonatal deaths.

August 2024:

- 2 x stillbirths, the first was at 29+1 weeks, triplet pregnancy where baby had a bradycardia (low heartbeat) which did not resolve, so an emergency Caesarean Section was performed, after 12 minutes of resuscitation, stillbirth was confirmed. The second was at 36+6 weeks, at consultant appointment, no fetal heartbeat seen on scan.

- 1 x neonatal death of woman, who was not booked at trust. Brought in by ambulance with vaginal bleeding and subsequently delivered an infant with signs of life, who was successfully resuscitated but died later that evening.

September 2024:

- No fetal losses, stillbirths, or neonatal deaths.

Areas of Learning:

- Blood results to be reviewed in a timely manner. Digital Midwife to update staff regarding the blood pools and how they are used.
- Timely assessment appointments to be made and then followed up.
- Trust policies and guidelines need to be followed to ensure women are seen appropriately.
- Continued issues with language barriers, where English is not the first language.
- Thematic review of Late Fetal Losses, Stillbirths and Neonatal deaths has been shared at divisional meetings and cascaded to staff.

Improvements Made: Learning is shared at forums, within training days, daily huddles and at team safety briefings. Collaboration is being undertaken with specialist teams to implement recommendations.

11.0 Conclusion

The outcome of the Trust's mortality surveillance programme continues to provide a rich source of learning that is supporting the organisations improvement objectives. The Trust continues to be recognised as having a low relative risk of mortality (SHMI) across NHS England.

We can provide assurance to the committee that we are providing safe care for the majority of patients. Where care issues are found, we have robust processes for referral for more in-depth review and these processes are triangulated against other data provided within the trust under the PSIRF framework.

We continue to align and improve our learning from patient death processes, and actively support the alignment across the acute provider collaborative to aid comparison, learning and opportunities for improvement.

12.0 Glossary

Medical Examiners are responsible for reviewing every inpatient death before the medical certificate cause of death (MCCD) is issued, or before referral to the coroner in the event that the cause of death is not known or the criteria for referral has been met. The Medical Examiner will request a Structured Judgement Review if required or if necessary refer a case for further review and possible investigation through our incident reporting process via the quality and safety team. The ME will also discuss the proposed cause of death including any concerns about the care delivered with bereaved relatives.

Structured Judgement Review (SJR) is a clinical judgement-based review method with a standard format. SJR reviewers provide a score on the quality of care provided through all applicable phases of care and will also identify any learning. The SJR will be completed within seven days of referral.

Structured judgement reviewers are responsible for conducting objective case note reviews of identified cases. They will seek, when required, specialist input and advice from clinical colleagues, including members of the multi-disciplinary teams to ensure high quality, comprehensive review is undertaken, using the full range of medical records available to them.

Specialty M&M reviews are objective and multidisciplinary reviews conducted by specialties for cases where there is an opportunity for reflection and learning. All cases where ME review has identified issues of concern must be reviewed at specialty based multi-disciplinary Mortality & Morbidity (M&M) reviews.

Child Death Overview Panel (CDOP) is an independent review aimed at preventing further child deaths. All child deaths are reported to and reviewed through Child Death Overview Panel (CDOP) process.

Perinatal Mortality Review Tool (PMRT) is a review of all stillbirths and neonatal deaths. Neonatal deaths are also reviewed through the Child Death Overview Panel (CDOP) process. Maternal deaths (during pregnancy and up to 12 month post-delivery unless suicide) are reviewed by Healthcare Safety Investigation Branch and action plans to address issues identified are developed and implemented through the maternity governance processes.

Learning Disabilities Mortality Review (LeDeR) is a review of all deaths of patients with a learning disability. The Trust reports these deaths to the Local integrated care boards (ICBs) who are responsible for carrying out LeDeR reviews. SJRs for patients with learning disabilities are undertaken within the Trust and will be reported through the Trust governance processes.

Appendix A – Acute Provider Collaborative performance scorecard

ME	2023-2024		2024-25	
	Q3	Q4	Q1	Q2
No. Deaths	665	595	560	556
No. Adult Deaths	660	593	555	552
Adult Deaths per 1000 Elective Bed Days	7.40	6.55	5.99	
No. Child Deaths	5	2	5	4
No. Neonatal Deaths	2	0	0	2
No. Stillbirths	1	7	3	2
ME Reviewed Deaths in Qtr.	665	595	560	549
% ME Reviewed Deaths - Deaths (excluding Stillbirths) in Qtr.	100%	100%	100%	99%
SJRs Requested for Deaths in Qtr.	77	64	83	135
% SJRs Requested for Deaths in Qtr. of total deaths in Qtr.	12%	11%	15%	24%
SJRs Completed for Deaths in Qtr.	75	59	74	115
% SJRs Completed for Deaths in Qtr.	97%	92%	89%	85%
No. LeDeR Completed	8	15	9	12
Requests made by a Medical Examiner - SJRs Requested for Deaths in Qtr.	12	17	26	42
% Requests made by a Medical Examiner - SJRs Requested for Deaths in Qtr.	16%	27%	31%	31%
Concerns raised by family / carers - SJRs Requested for Deaths in Qtr.	25	22	16	22
% Concerns raised by family / carers - SJRs Requested for Deaths in Qtr.	32%	34%	19%	16%
Patients with learning disabilities - SJRs Requested for Deaths in Qtr.	8	15	9	12
% Patients with learning disabilities - SJRs Requested for Deaths in Qtr.	10%	23%	11%	9%
Patients with severe mental health issues - SJRs Requested for Deaths in Qtr.heat	4	2	6	6
% Patients with severe mental health issues - SJRs Requested for Deaths in Qtr.	5%	3%	7%	4%
Unexpected deaths - SJRs Requested for Deaths in Qtr.	26	17	25	51
% Unexpected deaths - SJRs Requested for Deaths in Qtr.	34%	27%	30%	38%
Elective admission deaths - SJRs Requested for Deaths in Qtr.	5	9	7	12
% Elective admission deaths - SJRs Requested for Deaths in Qtr.	6%	14%	8%	9%

ME	2023-2024		2024-25	
	Q3	Q4	Q1	Q2
Requests made by speciality mortality leads/through local Mortality & Morbidity review processes - SJRs Requested for Deaths in Qtr.	1	3	4	10
% Requests made by speciality mortality leads/through local Mortality & Morbidity review processes - SJRs Requested for Deaths in Qtr.	1%	5%	5%	7%
Service or diagnosis alarms as agreed by APC mortality surveillance group - SJRs Requested for Deaths in Qtr.	3	2	n/a	n/a
% Service or diagnosis alarms as agreed by APC mortality surveillance group - SJRs Requested for Deaths in Qtr.	0.45%	0.33%	n/a	n/a
CESDI 0 - No suboptimal care - Completed SJRs for Deaths in Qtr.	56	41	57	89
% CESDI 0 - No suboptimal care - Completed SJRs for Deaths in Qtr.	75%	70%	77%	77%
CESDI 1 - Some sub optimal care which did not affect the outcome - Completed SJRs for Deaths in Qtr.	16	15	13	24
% CESDI 1 - Some sub optimal care which did not affect the outcome - Completed SJRs for Deaths in Qtr.	21%	25%	18%	21%
CESDI 2 - Suboptimal care – different care might have made a difference to outcome (possible avoidable death) - Completed SJRs for Deaths in Qtr.	3	3	4	2
% CESDI 2 - Suboptimal care – different care might have made a difference to outcome (possible avoidable death) - Completed SJRs for Deaths in Qtr.	4%	5%	5%	2%
CESDI 3 - Suboptimal care - would reasonably be expected to have made a difference to the outcome (probably avoidable death) - Completed SJRs for Deaths in Qtr.	0	0	0	0
% CESDI 3 - Suboptimal care - would reasonably be expected to have made a difference to the outcome (probably avoidable death) - Completed SJRs for Deaths in Qtr.	0%	0%	0%	0%

Appendix B: Ethnicity Q3 & Q4 2023/24 and Q1 & Q2 2024/25

	2023-24				2024-25						Community population
	Q3 n	Q3 %	Q4 n	Q4 %	Q1 n	Q1 %	Q2 n	Q1 %	Total n	Total %	Brent, Ealing, Harrow
Bangladeshi	0	0%	1	0%	1	**0.18%**	0	**0.00%**	**2**	**0.08%**	0.77%
Black African	12	2%	18	3%	14	**2.50%**	18	**3.24%**	**62**	**2.61%**	6.47%
Black Caribbean	24	4%	15	3%	14	**2.50%**	15	**2.70%**	**68**	**2.86%**	4.10%
Chinese	1	0%	1	0%	4	**0.71%**	1	**0.18%**	**7**	**0.29%**	1.10%
Indian	123	18%	101	17%	128	**22.86%**	112	**20.14%**	**464**	**19.53%**	21.00%
Mixed white and Asian	3	0%	0	0%	4	**0.71%**	1	**0.18%**	**8**	**0.34%**	1.27%
Mixed white and black African	0	0%	1	0%	0	**0.00%**	2	**0.36%**	**3**	**0.13%**	0.67%
Mixed white and black Caribbean	0	0%	3	1%	2	**0.36%**	1	**0.18%**	**6**	**0.25%**	1.07%
Not stated/Unknown	90	14%	79	13%	64	**11.43%**	53	**9.53%**	**286**	**12.04%**	N/A
Other Asian	67	10%	64	11%	31	**5.54%**	56	**10.07%**	**218**	**9.18%**	8.90%
Other Black	8	1%	13	2%	10	**1.79%**	15	**2.70%**	**46**	**1.94%**	1.33%
Other ethnic category	32	5%	29	5%	14	**2.50%**	13	**2.34%**	**88**	**3.70%**	5.23%
Other mixed	3	0%	11	2%	1	**0.18%**	2	**0.36%**	**17**	**0.72%**	1.70%
Pakistani	9	1%	9	2%	12	**2.14%**	13	**2.34%**	**43**	**1.81%**	4.33%
White - British	230	35%	208	35%	213	**38.04%**	204	**36.69%**	**855**	**35.98%**	20.00%
White - Irish	10	2%	11	2%	10	**1.79%**	9	**1.62%**	**40**	**1.68%**	2.37%
White - other white	53	8%	31	5%	38	**6.79%**	41	**7.37%**	**163**	**6.86%**	15.07%
No value	0	0%	0	0%	0	**0.00%**	0	**0.00%**	**0**	**0.00%**	N/A
Total	665	100%	595	100%	560	**100.00%**	556	**100.00%**	**2376**	**100.00%**	

Chelsea and Westminster Hospital NHS Foundation Trust
The Hillingdon Hospitals NHS Foundation Trust
Imperial College Healthcare NHS Trust
London North West University Healthcare NHS Trust

NWL Acute Provider Collaborative Board in Common (Public)
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The Hillingdon Hospitals NHS Foundation Trust Learning from Deaths report Quarter 2

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Purpose of report

Purpose: Information or for noting only

This report presents the data from the Learning from Deaths programme for Quarter Two (Q2) of 2024/25 for information. It is a statutory requirement for Trusts to present this information to their boards.

Report history

Committees or meetings where this item has been considered before being presented to this meeting.

Trust Quality and Safety Executive Committee	**Mortality Surveillance Group**	**Trust Quality and Safety Committee**
11/11/2024	13/11/2024	04/12/2024
Q2 Report presented	Q2 Report presented	Q2 Report presented

1. Executive summary and key messages

1.1. To provide the board with an update on the Trust Learning from Deaths programme from 1st July 2024 to 30th September 2024

1.2. Our Trust Hospital Standardised Mortality Ratio (HSMR and Standardised Hospital Mortality Indicator (SHMI) mortality rates remain below the NHS benchmark of 100.

1.3. All deaths in Quarter Two (164) have been reviewed by the Medical Examiner, with cases where there are concerns about the quality of care or agreed trigger highlighted on the Level 1 review form are referred for structured judgement review (SJR).

1.4 Medical The Registration of Deaths (Medical Examiner) Regulations were enforced on 9th September 2024 with significant changes to the process. The Hillingdon Hospital Medical Examiner service has been at the centre of the local process, and a smooth transition was achieved, without any unexpected complications.

1.5 We continue to review ethnicity data for deceased patients to support identification of potential health inequalities. We recognised from our last analysis of ethnicity data presented in our quarter one report and from ethnicity data presented by the other three Acute Provider Collaborative Trusts that it is difficult to make meaningful analysis or target improvements at this stage. However, we are committed to continue to review and develop our data and will provide updates on this work as we progress.

1.6 There is focused work with the divisions for all historical outstanding Structured Judgement Reviews to be completed and closed, with reporting of them in the next report.

1.7 The Mortality Surveillance Group continues to monitor the number of in-patient deaths and the number of Structured Judgement Reviews being triggered and completed.

Strategic priorities

Tick all that apply

☐ Achieve recovery of our elective care, emergency care, and diagnostic capacity
☐ Support the ICS's mission to address health inequalities
☐ Attract, retain, develop the best staff in the NHS
☒ Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation
☐ Achieve a more rapid spread of innovation, research, and transformation

Improving how we learn from deaths which occur in our care will support identification of improvements to quality and patient outcomes.

Impact assessment

Tick all that apply

☐ Equity
☒ Quality
☐ People (workforce, patients, families or carers)
☐ Operational performance
☐ Finance
☐ Communications and engagement
☐ Council of governors

Mortality case review following in-hospital death provides clinical teams with the opportunity to review expectations, outcomes and learning in an open manner. Effective use of mortality learning from internal and external sources provides enhanced opportunities to reduce in-hospital mortality and improve clinical outcomes and experience for patients and their families.

Main report

2. Learning and Improvements

2.1 Learning from Deaths (LFD) is a standard quarterly agenda item at the Trust Quality & Safety Committee where developments on the LFD agenda and learning is shared and to provide assurance on the Learning from Deaths process.

2.2 The Trust Mortality Surveillance Group meets bi-monthly. Data and learning are presented from level 1 reviews, Structured Judgement Reviews, and by way of divisional exception reports following Mortality and Morbidity meetings, which is then disseminated to all the directorates and throughout the divisions.

2.3 The learning from deaths policy was updated in August 2024 to ensure that the processes to disseminate learning are more robust.

2.4 Unplanned Care have a Learning Newsletter that is distributed throughout the whole division after each quality and governance forum, this includes learning responses from patient safety incidents and Structured Judgement Reviews.

2.5 A Safety Improvement group (SIG) is being established which will triangulate themes and learning, from investigations which will include Structured Judgement Reviews.

2.6 There have been no prevention of future deaths (PFD) notices issued following an inquest in this quarter.

2.7 **Patients with a learning disability/autism:** Three completed SJR's (11%) were received during this quarter for patients who had a learning disability/autism. Two of these cases were for patients who had died during quarter one. All three cases were graded as CESDI 0 (No suboptimal care).

2.8 There were common themes identified in all three cases around excellent communication with families and specialist opinion from multiple teams for advice and guidance in the patient's management. Ceilings of care was discussed with families and set early in the patient's admission and it was clear from the reviews that all teams made the patients clinical management, dignity and comfort a priority.

2.9 Eleven further SJR's received this quarter were also graded as 'Some suboptimal care which did not affect the outcome' (CESDI 1). Upon review there were areas for improvement and potential missed opportunities and these cases have all been sent to the divisions for review, with feedback to the teams involved, further discussion at M&M and consideration of actions.

2.10 One SJR completed highlighted a high acuity patient who was admitted to the Acute Medical Unit from the Emergency Department and required a further transfer to EMCU. Patients who remain for active treatment should be admitted to EMCU directly to avoid unnecessary downstream ward moves and facilitate timely critical interventions. Recommendation was for a review of EMCU Standard Operating Practice, staffing and capacity.

- This is on the Trust Risk Register with a business case for staff recruitment.

2.11 A further review highlighted that there was a delay in getting blood components to the ward for transfusion in an unwell patient, although it was agreed that it wouldn't have changed the patient's outcome. To understand why the delay occurred and to ensure similar incidents didn't occur a review was carried out.

- Review highlighted that the delay was around the prescribing of the blood but not ordering the G+S/Cross match.
- This was picked up by ward nurses who asked on-call Dr to request.
- There was no other systemic learning but that the systems in place had meant that it had been picked up and dealt with by the nursing staff.

3. Key themes

3.1 **Mortality rates**

3.2 The 12-month Hospital Standardised Mortality Ratio (HSMR) for the period June 2023 to May 2024 is 92.75 within expected range

3.3 Standardised Hospital Mortality Indicator (SHMI) data for the period April 2023 to June 2024 is 96.0 and remains below the NHS benchmark of 100.

3.4 **Diagnostic Groups reviews**

3.5 In line with the agreed process across the Acute Provider Collaborative reviews are completed either because their HMSR is above the national benchmark of 100 (there is a difference between observed and expected deaths) or because their HSMR has been increasing (within expected range).

3.6 No new diagnostic groups with a HSMR or SHMI mortality score above 100 have been identified in this quarter.

3.7 Review of four diagnostic groups previously reported following an increase in HSMR is is in progress and will be presented in the next report.

3.8 **Review of ethnicity data**

3.9 Work continues within the Trust and through the APC mortality surveillance group to understand the best way to analyse ethnicity data for our deceased patients to identify any patterns, trends or themes.

3.10 We recognised from our last analysis of ethnicity data presented in our quarter one report and from ethnicity data presented by the other three Acute Provider Collaborative Trusts that it is difficult to make meaningful analysis or target improvements at this stage. However, we are committed to continue to review and develop our data and will provide updates on this work as we progress.

3.11 **Ethnicity:**

- Local population statistics identified that 42% of 'White British' people make up the resident population for the London Borough of Hillingdon. 16% 'Asian or Asian British – Indian' made up the second largest proportion of the resident population while 'White – Any Other White Background' made up 8% of the identified ethnicity.
- 'White British' remains the most frequently identified ethnicity associated with in hospital mortality, which aligns with the demographic composition of our local population and accounting for 46% of deaths occurring during quarter two 2024/25. 'White – Any Other White Background' was again the second largest ethnic group accounting for 23% of deaths occurring. As noted in quarter one there were more fluctuations in the ration of other ethnic groups where numbers of deceased are small.
- We did not know the ethnicity of 2% of our deceased patients in quarter two.

3.12 **SJR referrals by ethnicity:**

- The 'White British' group made up the highest number of referrals, 72% in quarter two with again 'White – Any Other White Background' making up the second highest number of referrals accounting for 17%.

3.13 **Ethnicity by CESDI score breakdown:**

- 55% of completed SJRs for 'White – British' deaths resulted in a CESDI 1 score (six cases in total).

3.14 **Medical Examiner**

3.15 **Overview:**

3.16 The Medical Examiner Service in Hillingdon is responsible for scrutinising all deaths in hospital and identifying learning points, or deaths needing to be referred to the

Coroner. On 9th September 2024, The Registration of Deaths (Medical Examiner) Regulations were enforced. There were significant changes to the process, to the coronial response and the duty of all Attending practitioners to report deaths within our local area in which the Coroner's duty to investigate is not engaged, for scrutiny by a duly appointed Medical Examiner.

3.17 From July to September, the Medical Examiners (ME) have scrutinised 164 (100%) in-hospital deaths (including 1 child and 1 neonatal) of which 19 adults and 1 child (11.9%) were referred to the Coroner, with the Coroner retaining 13 (7.7%) for investigation: Nineteen were returned for certification with no requirement for further investigation. Medical Examiners assisted the Coroner in finding certifiers for 3 deaths where the GP had not seen the patient in the period following discharge from hospital in the 28 days before expected death (which became a non-problem on 9th September). Three of the Coroner referrals were because no certifying practitioner Was available in a reasonable timeframe. The Medical Examiners urgently reviewed 18 in-hospital deaths where their faith tradition required urgent registration and burial, including 4 making use of the weekend on-call service.

3.18 Further scrutiny identified 181 community deaths (139 from GP practices, 34 from the local Hospice and 4 from Mount Vernon Cancer Centre. The Trust have received referrals from 100% of local GP practices and assisted with referral of 15 (8.2%) community deaths to the Coroner of which 4 were kept for further investigation. Four community deaths were urgently reviewed by the Medical Examiners, (including out of hours) where their faith tradition required urgent registration and burial.

3.19 **Achievements:**

3.20 The Registration of Deaths Regulations 2024 were enacted by parliament on 11th April 2024, making Medical Examiner scrutiny a statutory requirement for all local deaths from 9th September 2024. This removed among other things, the 28-day rule, the need for Coroner referral when there is no need for investigation, and cremation forms. No death can be registered without Medical Examiner scrutiny, except coronial cases. The Hillingdon Hospital Medical Examiner service has been at the centre of the local process, and a smooth transition was achieved, without any unexpected complications. We had delivered preparatory workshops for Community stakeholders including Registrars, Funeral Directors, Crematorium staff and GPs and their administration staff. We have been the route for transmission of MCCD's from community to Register Office for 16 months now, and there was therefore no step change for those GPs who had engaged when it became mandatory for a Medical Examiner to sign the MCCD.

3.21 Our Community to hospital scrutiny ratios for Q2 are 46.6%.to 53.4%. The funding model is based on 45% Acute-sector, 55% Non-acute sector.

3.22 The Lead Medical Examiner had already updated the documentation to comply with the new statute in terms of changes to the registration forms.

3.23 **Challenges:**

3.24 We are adjusting patterns of work to compensate for the changes over the last year since the Cerner EPR implementation in Hillingdon Hospital on 3rd November 2023. There are plans to review the inability to inform GPs of an agreed cause of death via cerner.

3.25 There are still data quality issues with identification of deceased patients on Cerner, and there are still delays in informing the Medical Examiner Office of death. However, the Springboard function as described below demonstrated that progress can be made, albeit slowly.

3.26 **Improvements made:**

3.27 See the Achievements above. We have an even closer working relationship with local Registrars, Hospice and GP practices, and also with several other stakeholders

(Crematoria, Funeral Directors etc, who required reassurance), strengthened by statutory changes.

3.28 We have begun to be involved in the formation of a Task & Finish group looking at Cerner End-Of-Life processes and a Discharge Summary process review group. The first result of this initiative is the on-demand report of all hospital confirmations of death, with links to that patient's record. This represents a step towards the required efficiency in the process. It will soon be available to all staff.

3.29 We have led the way in implementation of advice from the General Register Office in process improvements when minor alterations are required to MCCDs in order to minimise delays, where Medical Examiners as co-signatories can make corrections.

3.30 **Recommendations:**

3.31 With the implementation of Statutory Medical Examiner scrutiny, there seems to be a new Sector-wide recognition of the need to incorporate Medical Examiner processes into all relevant systems in the hospital, including those around Cerner software. Meetings are planned to formulate and request some of the updated to place Medical Examiner processes within End-of-Life care, as per statutory requirement. The Hillingdon Medical Examiner team are ready to play a central role in these formulations.

3.32 **Level 1 Reviews and Structured Judgement Reviews (SJR)**

3.33 The 12-month rolling data table below shows the number of adults deaths that have occurred along with the number of level 1 reviews completed, SJRs requested and SJRs returned.

Data pulled on 25th October 2024

	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Total
Total number adult deaths - (Based on date of death)	182	216	166	162	726
Total number of Levels 1 reviews for adult deaths	182	216	166	162	726
Number of patients referred for SJR- (Based on date of death)	16	11	23	18	68
Number SJRs returned (Based on date of death)	12	8	19	4	43
Number of SJRs awaiting return	4	3	4	14	25

3.34 In quarter two 2024/25, Medical Examiners (ME) have scrutinised 162 adult patient deaths within the hospital with level 1 reviews being carried out for all of these cases. There is a consistent monthly 100% compliance rate for level 1 reviews being carried out which provides assurance around the level 1 review Trust process.

3.35 The percentage of inpatient deaths referred for a SJR in quarter two, 11% (18 cases), was lower compared to 14%, (23 cases) in quarter four.

3.36 'Requests by Medical Examiner' was the most common reason for SJR referral, accounting for 50% (n=9) of all referrals in the quarter.

3.37 'Family/Carer' concerns had previously been the top trigger for a SJR referral in the last two quarters, with themes identified around communication. It had been recognised that there was an opportunity for learning around End-of-Life care and teaching had been organised by the Palliative Care Team.

3.38 Twenty Seven completed SJRs were received during quarter two, eighteen of which were for deaths occurring in quarter one and quarter two. Nine completed SJRs were for deaths occurring in 2023/24. Fourteen (52%) of these completed reviews found no

suboptimal care (CESDI 0). All CESDI 0 cases have been sent to the divisions for their review.

3.39 A further eleven (41%) reviews found that some suboptimal care was identified but that this did not affect the patient outcome (CESDI 1). All CESDI 1 cases have been sent to the divisions for further review.

3.40 Two cases (7%) were received via the mortality review process as a CESDI 2; Suboptimal care – different care might have made a different outcome. Each of these cases were escalated as per Trust Policy for a decision on appropriate learning response. No common themes were identified across these cases.

3.41 In cases where there was found to be suboptimal care, problems in care were identified during patient's phase of care in thirteen reviews completed:

- Admission and Initial management (n=1)
- Ongoing care (n=9)
- Care during procedure (n=1)
- Perioperative care (n=0)
- End of Life care (n=2)

3.42 Reviews received in this quarter found no cases of Suboptimal care where it would reasonably be expected to have made a difference to the outcome (CESDI 3).

3.43 Evidence of excellent care has been recognised during patients' phase of care in a number of the reviews completed (n=8):

- Admission and Initial management (n=6)
- Ongoing care (n=3)
- Care during procedure (n=0)
- Perioperative care (n=0)
- End of Life care (n=5)

3.44 Trust target for completion of SJRs is now two weeks following update of the Trust Learning from Deaths Policy in August 2024, having previously been 21 days for completion. Meeting this target would provide us with contemporaneous review of cases which would allow us to identify issues and implement changes much sooner.

3.45 We recognise that the majority of our cases are not returned within this time and are currently comparing our process against the processes for completion at other Trusts in the APC to highlight where there are weaknesses in and with a view to improving the timely completion of these important reviews and to highlight where there are weaknesses.

3.46 Requests for outstanding SJRs are sent to clinicians and the divisions but there is now focused work with the divisions and regular meetings set up with Planned Care, to be agreed with Unplanned Care for regular review of all outstanding SJRs. Target is, with support of both divisions, for all outstanding historical SJRs to be completed and closed and reported in the next report.

3.47 **PMRT**

3.48 **Overview:**

- There were three stillbirths in Q2.
- The crude stillbirth rate is 2.96 per 1000 births.
- There was one neonatal death.
- There was one termination of pregnancy for congenital abnormalities in quarter two 2024.

3.49 **Challenges:**

- There was one stillbirth where the Fetal Growth Restriction (FGR) Guideline was not followed at booking.
- There is no national or local guidance surrounding freebirthing (unassisted childbirth without medical or midwifery assistance).

3.50 **Improvements made:**

3.51 There was a gap in actions identified from PMRT reviews being put on Give Me Data which was due to the Maternity Safety Team not being adequately resourced. Following the stillbirth review the Trust now has a dedicated PMRT Midwife who will put the PMRT reviews on Give Me Data and this sends a prompt to staff to update any actions assigned to them.

3.52 **Recommendations:**

- To consider developing a local guideline on freebirthing to give to women and birthing people.
- We are awaiting sector wide guidance on updating the FGR guideline to align with Saving Babies Lives v3.

3.53 **LeDeR**

3.54 **Overview:**

3.55 As a Trust we follow the LeDeR programme to improve healthcare for people with Learning Disabilities and Autism.

3.56 Having Learning Disability nurses in post in acute and community settings is part of the NHS Long Term Plan to improve the quality of care for people with a Learning Disability or Autism. At the Hillingdon Hospital NHS Foundation Trust the Learning Disability Clinical Nurse Specialist works alongside Safeguarding, acting as an acute liaison supporting all patients with a Learning Disability.

3.57 For patients that have been notified to LeDeR and a review completed data, which includes the demographics of the patient, their health and lifestyle is used to inform local population health strategies. All local LeDeR leads have access to this on-line tool which can be used to review local needs for service improvement.

3.58 A LeDeR reviewer considers the health and social care a person received to identify any areas of good practice as well as any for improvement. Medical Examiners and/or Doctors are asked to share or discuss information/ with the LeDeR reviewer as part of the process.

3.59 There has been one case for a patient who died in quarter two who was identified as having a learning disability/autism and whose details have been submitted onto the LeDeR portal for review.

3.60 Anyone who knew the deceased patient, including family and professionals can notify LeDeR of a death of someone with a Learning Disability and/or Autism.

3.61 The Trust is currently strengthening the process in which the outcome of the Learning from Lives and Deaths Panel review once published and redacted by NWL ICB, can be shared at the Mortality Surveillance Group and Patient Safety Group for information.

3.62 **Challenges**

3.63 The reasonable adjustment flag is not live on Cerner. Having this would be beneficial in identifying a patient with a Learning Disability and/or Autism who may need more support and reasonable adjustments made for them.

3.64 LeDeR reviewers are now requesting medical records in respect of the deceased patient as well as the completed Structured Judgement Review.

3.65 **Improvements made:**

3.66 Reviews and learning panel outcome are assessed across North West London (NWL). The Hillingdon Hospital Learning Disability Clinical Nurse Specialist has developed strong links with a number of external network groups and professionals and works in

partnership with the Bereavement Team and Clinical Governance Facilitator here to support the mortality process and LeDeR reviews.

3.67 **Good Practice within Hillingdon Hospital**

3.68 Mandatory training now includes Autism awareness and there continues to be increased staff awareness of reasonable adjustments that may be needed for any patients with a Learning Disability/Autism.

3.69 Linking in with the HATS (patient transport) team and Hillingdon Hospital Outpatients for patients who may require support or reasonable adjustments made when attending their appointment.

3.70 The Trust is part of the NWL Learning Disabilities network looking at a general Learning Disability and Autism tool kit which would be added to CERNER and with a common SNOMED CT code to ensure we capture patients with a Learning Disability and/or Autism.

3.71 **CDOP**

3.72 **Overview:**

3.73 During this quarter there were two deaths in children who were brought to The Hillingdon Hospital Paediatric Emergency Department in Cardiac Arrest:

- 7yrs girl: complex medical background (microcephaly, global delay, epileptic encephalopathy). Multiple previous admissions with vomiting. Found unresponsive at home, intubated by the London Ambulance Service, required maximal doses adrenaline to maintain output, care redirected with parents present. Initial Incident Review (IIR) completed with no concerns, although some challenges with organising Mortuary Viewings.
- Day 4 baby: freebirthed with minimal obstetric monitoring due to parental request. Group B Streptococcus positive but refused antibiotics. Only engaged with 1 Health Care Professional, parents only gave consent for weight at Day2. Found unresponsive post feeding, resuscitation unsuccessful.
  Learning: decisions surrounding safeguarding thresholds for referral, increase in freebirthing seen nationally and associated deaths. Escalated to National Child Mortality Database.

3.74 Within the borough there was also a death by drowning in a 17yr boy whilst on a school trip, known to be non-swimmer. Review is ongoing.

3.75 **Improvements made and Challenges:**

3.76 Since September 2024, the North West London Child Death Review Team is now fully staffed. For improved transparency, child death reviews will now be scrutinised by a 'Designated Doctor' from a different borough and place of work and the challenge will be to ensure that local learning is fed back to Trusts in a timely and effective manner.

3.77 Themed panel reviews have commenced – the final scrutiny of deaths will now be completed along with similar cases/themes across North West London with the aim to improve the learning and scrutiny with expert opinions and for shared learning.

3.78 **Recommendations:**

3.79 Out of hours guidance on viewings is currently being finalised due to mortuary viewings not being possible over the winter months or out of hours.

4. Areas of focus

4.1. Cerner EPR

4.2. Although the number of patient deaths are captured through Level 1 reviews via the Medical Examiner Service, as highlighted in quarter one report there is still a discrepancy with some of the mortality data being captured by the Digital Services Team and we need to ensure our mortality data accurately reflects the correct figures. Issues identified around deaths are:

- Patients are not discharged off Cerner – These are then not counted in reporting.
- Patients are discharged with an incorrect discharge method (should always be 4-Died or 5-Stillbirth) – These are then not considered deaths.
- Patients not discharged on the day they died (the date of death is different to the discharge date) – These deaths are reported in different week of the month/month but only surface once discharged.
- Confirmation of Death Form is not always recorded – This is more of a workflow issue and is still being reviewed to assess the impact it has on reporting.

4.3 A weekly Mortality Data Quality report which includes each of the issues identified is sent to the Divisional Directors and Chief Nurse Information Officer for dissemination to the affected areas and there is continued work with the Cerner 'Super Users' on the wards.

4.4 Monitoring of compliance, learning and actions

4.5 The Trust does not currently have a digital platform for mortality. As outlined in previous reports we are still exploring, and in discussion with the Acute Provider Collaborative, different systems that will support with monitoring compliance, triangulation of data and learning from incidents, audit, complaints and mortality for us all. This will support with improving the completion of SJRs and monitoring and evidencing the learning that is identified as part of the Structured Judgement Review.

4.6 Specialty Mortality and Morbidity meetings

4.7 Work continues to review Specialty Mortality and Morbidity (M&M) meetings in Planned Care. With support from the Governance Manager for Planned Care we are continuing to support them all with trialling of a standardised slide deck template which will capture learning following discussion and recommendations agreed to be taken forward from the M&M meeting

4.8 Divisional exception reports following M&M meetings are being presented and discussed at the Mortality Surveillance Group meeting (MSG). This provides an overview of learning with the opportunity for any case discussion, actions being taken and escalation for MSG to take forward.

4.9 Mortality Leads

4.10 As previously reported there remain vacant posts for a mortality lead in Medicine and Surgery, however these roles are being considered as part of the Learning from Deaths process.

4.11 Completion of SJR and learning from deaths

4.12 The current learning from deaths policy has an expectation that all consultants will potentially undertake the SJR process for deaths identified within their clinical areas and complete reviews within 2 weeks. We know that the completion rate for these SJRs is lower than expected and slow. The quality of these reviews is variable and so there may be missed opportunity for learning. The Trust is currently comparing processes for completion for SJRs at other Trusts in the APC, which will highlight where there are weaknesses in our process and with a view to improving the timely completion of these important reviews. This work has oversight from the Trust Mortality Surveillance Group.

5. Conclusion

5.1 We can provide assurance to the committee that we are providing safe care for the majority of patients. Where care issues are found, we have robust processes for referral for more in-depth review and these processes are triangulated within the Trust under the PSIRF framework.

5.2 The Registration of Deaths (Medical Examiner) Regulations were enforced on 9th September 2024 with significant changes to the process. The Hillingdon Hospital Medical Examiner service has been at the centre of the local process, and a smooth transition was achieved, without any unexpected complications.

5.3 Work continues to align and improve our learning from patient death processes, and actively support the alignment across the acute provider collaborative to aid comparison, learning and opportunities for improvement.

5.4 We are continuing to explore different systems that will support with monitoring SJR compliance rate, learning and triangulation of data from SJRs, incidents, audit, and Complaints.

5. Glossary

a. **Medical Examiners** are responsible for reviewing every inpatient death before the medical certificate cause of death (MCCD) is issued, or before referral to the coroner in the event that the cause of death is not known or the criteria for referral has been met. The Medical Examiner will request a Structured Judgement Review if required or if necessary refer a case for further review and possible investigation through our incident reporting process via the quality and safety team. The ME will also discuss the proposed cause of death including any concerns about the care delivered with bereaved relatives.

b. **Structured Judgement Review (SJR)** is a clinical judgement based review method with a standard format. SJR reviewers provide a score on the quality of care provided through all applicable phases of care and will also identify any learning. The SJR will be completed within seven days of referral.

c. **Structured judgement reviewers** are responsible for conducting objective case note reviews of identified cases. They will seek, when required, specialist input and advice from clinical colleagues, including members of the multi-disciplinary teams to ensure high quality, comprehensive review is undertaken, using the full range of medical records available to them.

d. **Specialty M&M** reviews are objective and multidisciplinary reviews conducted by specialties for cases where there is an opportunity for reflection and learning. All cases where ME review has identified issues of concern must be reviewed at specialty based multi-disciplinary Mortality & Morbidity (M&M) reviews.

e. **Child Death Overview Panel (CDOP)** is an independent review aimed at preventing further child deaths. All child deaths are reported to and reviewed through Child Death Overview Panel (CDOP) process.

f. **Perinatal Mortality Review Tool (PMRT)** is a review of all stillbirths and neonatal deaths. Neonatal deaths are also reviewed through the Child Death Overview Panel (CDOP) process. Maternal deaths (during pregnancy and up to 12 month post-delivery unless suicide) are reviewed by Healthcare Safety Investigation Branch and action plans to address issues identified are developed and implemented through the maternity governance processes.

Learning Disabilities Mortality Review (LeDeR) is a review of all deaths of patients with a learning disability. The Trust reports these deaths to the Local integrated care boards (ICBs) who are responsible for carrying out LeDeR reviews. SJRs for patients with learning disabilities are undertaken within the Trust and will be reported through the Trust governance processes.

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List of appendices

Appendix 1 – Performance Scorecard

Appendix 2 – Ethnicity

Appendix 3 – Flow Chart referral to LeDeR

Appendix 1 – Performance Scorecard

	Q3	Q4	Q1	Q2	Comments	National LfD minimum requirement?
Summary data						
Total no. deaths (adult and children, including neonatal and excluding stillbirths)	184	218	167	164	Inpatient deaths only	
Total no. adult deaths	182	216	166	162	Inpatients over 18 years age	Y
No. adult deaths per 1,000 non-elective bed days	TBC	TBC	TBC	TBC		
Total no. child deaths	1	1	1	1	Inpatients over 28 days and less than 18 year only	
Total no. neonatal deaths	1	1	0	1	Inpatients livebirths under 28 days of age	
Total no. stillbirths	3	5	1	3	Inpatient not live births	
Review summary						
Deaths reviewed by Medical Examiner	184	218	167	164		
% Deaths reviewed by Medical Examiner	100%	100%	100%	100%	% of total deaths	% of row 1
Deaths referred for Level 2 review	16	11	23	18		
% Deaths referred for Level 2 review	9%	5%	14%	11%	% of total adult deaths	% of row 2
Level 2 reviews completed	12	8	19	4		
% Level 2 reviews completed	75%	73%	83%	23%	% of total referrals this quarter	Y
Total Deaths Reviewed Through the LeDeR Methodology	3	0	4	1		
Level 2 referral reason breakdown						
Requests made by a Medical Examiner	(7) 44%	(1) 9%	(6) 26%	(9) 50%	% of total referrals	
Concerns raised by family / carers	(4) 25%	(7) 64%	(9) 39%	(3) 17%	% of total referrals	

Patients with learning disabilities	(3) 19%	(0) 0%	(4) 17%	(1) 6%	% of total referrals	
Patients with severe mental health issues	(2) 13%	(3) 27%	(2) 9%	(2) 11%	% of total referrals	
Unexpected deaths	(0) 0%	(0) 0%	(5) 22%	(1) 6%	% of total referrals	
Elective admission deaths	(2) 13%	(1) 9%	(1) 4%	(1) 6%	% of total referrals	
Requests made by speciality mortality leads / through local Mortality and Morbidity review processes	(0) 0%	(0) 0%	(1) 4%	(1) 6%	% of total referrals	
Service or diagnosis alarms as agreed by APC mortality surveillance group	(0) 0%	(0) 0%	(0) 0%	(0) 0%	% of total referrals	
Random selection of deaths for SJR review	(0) 0%	(0) 0%	(0) 0%	(3) 17%		
Level 2 review outcomes						
CESDI 0 - No suboptimal care	9	6	8	1	% of cases reviewed	Total Figure
CESDI 1 - Some sub optimal care which did not affect the outcome	3	2	10	2	% of cases reviewed	Total Figure
CESDI 2 - Suboptimal care – different care might have made a difference to outcome (possible avoidable death)	0	0	1	1	% of cases reviewed	
CESDI 3 - Suboptimal care - would reasonably be expected to have made a difference to the outcome (probably avoidable death)	0	0	0	0	% of cases reviewed	Y
SHMI and HSMR						
SHMI 12-month rolling					Provided by Telestra Health UK	
HSMR 12-month rolling					Provided by Telestra Health UK	
Palliative Care SHMI 12-month rolling					Provided by Telestra Health UK	
Palliative Care HSMR 12-month rolling					Provided by Telestra Health UK	

Appendix 2 – Ethnicity

		2023/24		2024/25		2023/24		2024/25	
	Total	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Asian - Any Other Asian Background	49	19	8	11	11	10.33%	3.67%	6.58%	6.71%
Asian or Asian British - Bangladeshi	0	0	0	0	0	0.00%	0.00%	0.00%	0.00%
Asian or Asian British - Indian	87	18	20	22	27	9.79%	9.17%	13.17%	16.46%
Asian or Asian British - Pakistani	6	4	1	0	1	2.17%	0.46%	0.00%	0.61%
Black - Any Other Black Background	3	1	0	2	0	0.54%	0.00%	1.20%	0.00%
Black or Black British - African	16	5	3	6	2	2.72%	1.38%	3.59%	1.22%
Black or Black British - Caribbean	9	1	4	3	1	0.54%	1.83%	1.80%	0.61%
Mixed - Any Other Mixed Background	1	0	0	0	1	0.00%	0.00%	0.00%	0.61%
Mixed - White and Asian	1	0	0	0	1	0.00%	0.00%	0.00%	0.61%
Mixed - White and Black African	1	0	0	0	1	0.00%	0.00%	0.00%	0.61%
Mixed - White and Black Caribbean	1	0	0	0	1	0.00%	0.00%	0.00%	0.61%
Other - Any Other Ethnic Group	35	10	18	4	3	5.43%	8.26%	2.39%	1.83%
Other - Chinese	3	1	1	1	0	0.54%	0.46%	0.60%	0.00%
Other - Not Known	3	0	0	0	3	0.00%	0.00%	0.00%	1.83%
Other - Not Stated	0	0	0	0	0	0.00%	0.00%	0.00%	0.00%
White - Any Other White Background	123	18	44	24	37	9.79%	20.18%	14.37%	22.56%
White - British	387	104	117	91	75	56.52%	53.67%	54.50%	45.73%
White - Irish	8	3	2	3	0	1.63%	0.92%	1.80%	0.00%
Total	733	184	218	167	164	100.00%	100.00%	100.00%	100.00%

APPENDIX 3 – Flow Chart referral to LeDeR